

2020 Benefits Administrator Manual



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General information

General information

This manual will help you prepare insurance benefits paperwork and documentation required by the S.C. Public Employee Benefit Authority (PEBA). It outlines rules, regulations, policies and procedures, and contains an abbreviated description of insurance benefits offered by or through PEBA.

When determining benefits, the [Plan of Benefits](#) supersedes all other publications. That document contains a complete description of the State Health Plan. Its terms and conditions govern all health benefits under the Plan. The *Plan of Benefits* is available on PEBA's website. There are also [plan documents available](#) for the dental plans and MoneyPlus. For other benefits, the respective contract with PEBA supersedes all other publications.

The [Insurance Benefits Guide](#) provides summaries of the various insurance programs offered by PEBA and is available on PEBA's website. The guide is mailed to retirees, COBRA subscribers and survivors for whom PEBA does not have an email address. The [Insurance Summary](#) provides a high-level overview of insurance benefits offered by PEBA. The summary is distributed to active employees.

All participating employers must offer their insurance-eligible subscribers all the insurance programs that PEBA offers:

- Health insurance benefits (State Health Plan and the GEA TRICARE Supplement Plan);
- Health and wellness programs;
- Dental insurance (Dental Plus and Basic Dental);
- State Vision Plan;
- Life insurance (Basic, Optional Life and Dependent Life);
- Long term disability (Basic and Supplemental); and
- MoneyPlus (all plans, as eligible).

Employers may not offer competing products and programs that PEBA already offers. Employers may offer products not offered by PEBA; however premiums for those products may not be paid pretax through MoneyPlus.

Benefits administrators and others chosen by your employer who may assist with insurance enrollment, changes, retirement or termination and related activities are not agents of the S.C. Public Employee Benefit Authority and are not authorized to bind the S.C. Public Employee Benefit Authority.

The language used in this document does not create an employment contract between the employee and S.C. Public Employee Benefit Authority. This document does not create any contractual rights or entitlements. The S.C. Public Employee Benefit Authority reserves the right to revise the content of this document, in whole or in part. No promises or assurances, whether written or oral, which are contrary to or inconsistent with the terms of this paragraph create any contract of employment.

How to use this manual

The manual is divided into sections that address the types of subscribers you assist. The manual's table of contents is combined to make it easier to locate the information you need. Each section of the manual also includes a contents page.

Forms on the web

The forms mentioned in this manual are included on PEBA's website, www.peba.sc.gov. To find those specifically for employers, select Insurance Benefits then Employers. Most forms are under Insurance Benefits, then Forms.

EBS website

The Employee Benefits Services (EBS) website at <https://ebs.eip.sc.gov> gives you instant, online access to insurance enrollment information, reporting data and billing reports. PEBA recommends you sign up and take advantage of EBS right away, if you have not already done so. Through EBS, you can:

- Access subscriber and spouse and/or child(ren) record information.
- Enroll new employees and make coverage changes.
- Review and approve changes your employees make using MyBenefits.
- Receive statements and reports.
- Update SLTD salary information.

Refer to Using the online enrollment system chapter for information on EBS, how to sign up and how to use online enrollment and subscriber data management features of EBS.

Contact PEBA

Address

202 Arbor Lake Drive
Columbia, SC 29223

Website

www.peba.sc.gov

Email

Select Contact us at the bottom of www.peba.sc.gov and select the appropriate form.

Customer Contact Center

803.737.6800 | 888.260.9430

When you call PEBA on behalf of a subscriber

Be sure the subscriber has already attempted to resolve the issue by contacting the third-party claims processor, plan administrator or PEBA. There are excellent online resources available to subscribers, and they should be encouraged to use them. If you do need to call PEBA:

- Have the SSN or Benefits ID Number (BIN) of the individual ready.
- Have your question ready and please be specific.
- Remember HIPAA guidelines. PEBA cannot release personal health information to you, except enrollment and premium information, unless the subscriber has signed an [Authorized Representative Form](#) and filed it with PEBA, thereby giving you access to his personal health information.

Requests for proof of insurance

Individuals often need proof of health insurance when they travel overseas, particularly if they are students or will be employed in another country. PEBA is glad to provide these letters. However, it may take up to 10 working days to process these requests. Please encourage subscribers to request proof of insurance as soon as they know they need it.

Training and resources

Employer Services and the Field Services team at PEBA are committed to supporting employers. Staff is available to assist employers with training, seminars, benefit fairs and field visits. An insurance benefits support menu is online at www.peba.sc.gov/employers.html. Contact the Employer Services department by email at EmployerServices@peba.sc.gov.

Training classes explain the benefit plans and procedures, and they are designed to help benefits administrators better inform and counsel employees about their insurance coverage and benefits. Benefits administrators and personnel/payroll staff are encouraged to attend. The trainings are offered by PEBA at no charge. Presentations are available at www.peba.sc.gov/trainingresources.html.

A training calendar is available at www.peba.sc.gov/employers.html. Benefits administrators can register for a class online at www.peba.sc.gov/events.

Part of the role of the benefits administrator is to inform employees of their benefits. Please take advantage of the publications PEBA produces, which are all on the PEBA website at www.peba.sc.gov/iresources.html. Benefits administrators also have access to the PEBA Health Hub at www.PEBAHealthHub.com. Turnkey marketing toolkits for a variety of topics are available for download.



Using the online enrollment system

Using the online enrollment system

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Online enrollment system terms

Employee Benefits Services

[Employee Benefits Services](#) (EBS) is an online software application through which you can access PEBA's insurance enrollment database. EBS gives you instant access to your subscribers' insurance enrollment information and your employer's reporting data and billing reports. When you register for EBS's Online Enrollment System, you can enroll your subscribers, view their benefits, make changes to their coverage and approve changes your subscribers make using MyBenefits. The Online Enrollment System will allow you to submit enrollment changes for your subscribers using two methods. One method, Current EBS, generates enrollment forms that must be signed by you and your subscriber and submitted to PEBA. The other method, MyBenefits, uses electronic signatures and allows employees to upload required documentation.

MyBenefits

[MyBenefits](#) is an online software application that allows active subscribers, retirees, survivors and COBRA subscribers to access their own enrollment information in PEBA insurance benefits' enrollment database. Through MyBenefits, they can view their enrollment information and make some enrollment changes to their coverage, as well as approve changes you make in EBS and submit to them. Most transactions are paperless and employees can upload supporting documentation.

Summary of Enrollment (SOE)

This document is generated when a new enrollment is completed online. The SOE is an official document that replaces a paper *Notice of Election* (NOE).

Summary of Change (SOC)

This document is generated when an enrollment change is completed online. The SOC is an official document that replaces a paper *Notice of Election* (NOE).

Summary of Intent (SOI)

This document is generated when an open enrollment change is completed online through MyBenefits. The SOI is a summary of the subscriber's intended changes but does not necessarily display his final choices because he can make multiple changes online throughout October. After midnight on October 31, PEBA accepts the last change the subscriber submitted.

Summary of Termination

This document is generated when a termination is completed online. This is an official document that replaces a paper *Active Termination Form*.

Employee Benefits Services (EBS)

PEBA requires all benefits administrators to sign up for [Employee Benefits Services](#) (EBS).

Signing up for EBS

To sign up for and access EBS, you will need:

Internet access

A compatible browser

- PEBA web applications support the current and previous major releases of the following browsers: Internet Explorer, Chrome, Firefox and Safari running on the Windows or Mac OS operating system. Each time a new version of a browser is released, PEBA begins supporting that version and stops supporting the third-most recent version.

Adobe Acrobat Reader software

- Many modern browsers include a built-in PDF viewer. PEBA supports the built-in PDF viewers in Chrome, Firefox and Safari, and it supports the latest version of Adobe Acrobat Reader.

A valid EBS user ID

- The user ID is assigned by PEBA and is a vital part of protecting confidential information.

It also is used to track who is using the system, how often and the exact functions used by the individual.

To complete and forward to PEBA the following forms:

- [EBS Confidentiality Agreement](#);
- [EBS Authorizing Agent Designation Form](#); and
- [EBS Designated Employee Confidentiality Agreement](#).
- If your employer uses a third-party enroller (TPE), these forms must also be completed and sent to PEBA:
 - [Memo of Understanding \(for Third-Party Enrollers\)](#); and
 - [TPE Designated Employee Confidentiality Agreement](#).

These EBS documents are on the PEBA website at www.peba.sc.gov/iemployers.html. Send all EBS forms from your office to PEBA in one envelope. Once approved, a confidential user ID will be sent to you in the mail. A PIN will follow in a separate mailing.

Once you are approved, if you have any problems accessing the EBS website or with your user ID and PIN, call PEBA's Customer Contact Center at 803.737.6800.

PEBA will send a letter to your authorizing agent to complete and return by June 30 each year to recertify employees' access to EBS. To change an employee's access or add a new EBS user, the authorizing agent must submit a new [EBS Designated Employee Confidentiality Agreement](#).

EBS homepage

The buttons on the left side of the homepage are accessible to you based on your Confidentiality Agreement with PEBA. If your user ID does not allow access to a function, the tab for that function will be grayed out.

- **Inquiry** View detailed insurance information about a subscriber within your group(s).

Search by SSN or last name. Also view suspense records for your group.

- **Manage** Enroll a new subscriber, make changes to current subscribers or terminate coverage for a subscriber.
- **Enroll. File Upload** Submit a file in PEBA's approved format to initiate enrollment elections for new hires through MyBenefits.
- **Enroll Reports** View your enrollment reports online.
- **Accounting Reports** View your billing statements and reports online.
- **Balance** View your accumulated balance.
- **Contacts** View and change your employer contact information.
- **SLTD Salary Entry** Enter SLTD salary updates online; available for yearly updates during the open enrollment period. This does not apply to CG agencies.
- **Online Bill Pay** Remit insurance payments online.
- **PEBA Insurance Home** Access the PEBA website.
- **Download Forms** Access forms on PEBA's website.
- **Carrier Links** Access insurance resources on PEBA's website.
- **Contact Us** View PEBA's contact information and email PEBA's Customer Contact Center.
- **Browser Support** View information regarding internet browser requirements to use PEBA's online applications.
- **Change Password**
- **Log Out**

BA Console

The BA Console is the tool in the middle section of the EBS homepage that allows you to manage changes to your subscribers' coverage. The results of all enrollment transactions, whether initiated by you or initiated by your subscribers, will appear on this console. The console consists of four tabs: Suspended, Acknowledgement, Approval and Current EBS.

See Page 27 for more information about the BA Console.

Inquiry

Search for coverage information about subscribers from your group by SSN, BIN or name through a Subscriber Inquiry. Subscriber Summary of Change (SOC) documents can also be searched by SSN.

Search for suspense transactions for your group by SSN, BIN or your group number through a Suspense Inquiry.

Manage subscribers

From the Manage Subscribers section on the homepage, you can indicate the type of transaction to be processed or initiate a subscriber or suspense inquiry. Select one of the following actions from the drop-down list:

- Enroll;
- Change;
- Terminate;
- Subscriber Inquiry;
- Suspense Inquiry; or
- Subscriber SOCs.

The **Manage** button on the EBS homepage also allows you to enroll, change or terminate.

Enroll. File Upload

Upload a .csv or .xlsx file if you have multiple new hires. Download a template and access instructions about what you should include in the file and upload a file, by selecting this button.

Once the file is uploaded, employees will receive an email, and EBS will create a suspense record. Employees should follow the link in the email to access the MyBenefits page. Employees will be prompted to enter name, date of birth and Social Security number. An address and enrollment selections are also required.

Employees can choose to upload any supporting documents, as well. Once the employee submits his

information, you will see the transaction on the Approval tab in EBS.

Enroll

Enrolling a new employee or an employee transferring from another employer.

- From Manage Subscribers, select Enroll from the drop-down list.
- Enter the SSN of the employee.
- Enter your Group ID if it does not automatically populate the field.
- Select how to complete the enrollment (by the employee through MyBenefits, or through EBS).

MyBenefits Enrollment

Complete the required information on the Enrollee Data tab, including a valid email address, salary and date of hire. Select Apply.

The employee will receive an email, and EBS will create a suspense record. The employee should follow the link in the email, which will take him to the MyBenefits page. The employee will be prompted to enter his name, date of birth and Social Security number. He must also enter an address and make his enrollment selections.

The employee can choose to upload any supporting documents, as well. Once the employee submits his information, you will see the transaction on the Approval tab in EBS.

EBS Enrollment

Tabs will appear for you to enter the required information on each tab.

Enrollee Data tab

System edits will prompt the required data, return error messages and help text where applicable.

Complete the required information.

Select Next to move to the Dependents tab.

Dependents tab

If the subscriber is married, the spouse must be listed, regardless of whether the spouse is covered.

If the subscriber is not married and has no eligible child(ren) for whom he is electing benefits, move to the Coverage tab by selecting Next.

If the subscriber was enrolled previously with a spouse or child(ren), the spouse or child(ren) may be selected from the Reactivate Dependent List.

Select the number of dependents from the drop-down list and press Add.

Complete the required information for the dependents (an SSN is required for any child age 1 or older).

- Beside each coverage type, select Activate from the drop-down list or leave the status blank if you are not adding the dependent to the benefits. The system will show the Dependent Life choice based on the relationship entered above.
- Enter Other Coverage information, when applicable, if the dependent is enrolling in health coverage. The system defaults to No. If changed to Yes, complete the required information. (The requested date of birth is that of the policyholder of the other plan.)
- Medicare coverage question defaults to No. Change to Yes and complete the required information, if applicable.
- You may Add More Rows of dependents by selecting from the drop-down list. The system will add the additional number of fields indicated.

Select Next to move to the Coverage tab.

Coverage tab

Benefit election choices for the Coverage tab will populate based on the information entered on the Dependents tab.

Examples: If no spouse or children are listed, you will not see a choice for Dependent Life. Also, if health coverage is selected for both a spouse and child(ren) on the Dependents tab, the health plan category will default automatically to *full family*.

If not already populated, select the coverage elections or refuse coverage from the drop-down options.

Only if you elect the Standard or Savings Plan will tobacco use default to Tobacco Coverage. Change to Refused if the subscriber and dependents are not tobacco users.

If electing Dental, also select Yes or No for Dental Plus.

If electing Optional Life, select the coverage level from the drop-down list. For a new hire, the maximum amount of coverage that may be keyed into the system is three times salary (rounded down). If the employee wants a higher level of coverage, the employee must complete and submit a *MetLife Statement of Health* form and a paper *Notice of Election* form.

Dependent Life-Spouse will populate automatically, based on whether a spouse was entered on the Dependents tab. Select a coverage level of either \$10,000 or \$20,000. If the **subscriber** wants a higher level of coverage, he must complete and submit a *MetLife Statement of Health* form and a paper *Notice of Election* form. This field will not appear if there is no eligible spouse.

Dependent Life-Child will populate automatically, based on the information entered on the Dependents tab. This field will not appear if there are no eligible children.

If electing SLTD, select the coverage type from the drop-down list. The system will pull the salary from the Enrollee Data tab.

The Pretax Group Insurance Premium feature field will default to Refused but can be changed to Active.

MoneyPlus accounts will be listed based upon the health plan selected. Enter the annual contribution amount for each account or leave as \$0 to refuse enrollment.

- Standard Plan: Medical Spending Account and Dependent Care Spending Account.

- Savings Plan: Health Savings Account, Limited-use Medical Spending Account and Dependent Care Spending Account.

If an annual contribution amount is entered for a MoneyPlus account, enter the Total Annual Pay Periods from the drop-down list.

Select Next to move to the Beneficiaries tab.

Beneficiaries tab

If the desired beneficiary is a spouse or child listed on the Dependents tab, press Add beside Add from existing dependent list. Select the dependents from the list and select Add Selected Dependents to Beneficiaries. The personal information and relationship of the dependent(s) will populate automatically.

To add more beneficiaries, select the number of beneficiaries from the drop-down list and press Add.

Complete the required beneficiary information, indicate the life insurance program by clicking on the box beside the elected programs, indicate the percentage if not equally divided among the beneficiaries, and select Primary or Contingent from the drop-down list.

Select Next to move to the Review tab.

Review tab

The Review tab is a complete list of all information entered on the previous tabs. The type of action taken and the effective date will be at the top of the page.

From this page you may return to any tab by selecting on the tab at the top of the page if adjustments to the information are needed.

The **Summary of Enrollment (SOE)** is a complete list of the subscriber's elected benefits, ID data, spouse and child(ren) information, and beneficiary information. The SOE is an official document that replaces a paper *Notice of Election (NOE)*.

The effective date of the transaction will be shown at the top, along with a description of any documentation that may be required.

You may Suspend, Cancel or Apply the transaction by selecting the desired button (top right of page).

- **Suspend** will allow you to keep what has already been processed, and you may retrieve it at a later date. It will be on the Suspended tab of the BA Console and will be listed as Incomplete. You will receive a SUSPEND message box, inside which you enter the reason for suspending the file.
- **Cancel** will remove the entire transaction. Once you confirm to cancel, it cannot be recovered.
- **Apply** the transaction and choose either Current EBS to generate a paper SOE or MyBenefits (see Page 15) to generate a paperless SOE. Selecting MyBenefits allows the employee the option to upload required documentation.

If you apply the transaction to Current EBS, a printed SOE must be signed by the benefits administrator and the subscriber within 31 days of the hire date and uploaded or sent to PEBA.

From the Current EBS tab on the BA Console, select the transaction.

1. Select the **Print Signature Sheet** button to print the barcode-signature sheet. The document will open in a new window. The benefits administrator signature and date and the subscriber's signature and date are required on the signature page.
2. If you need to print or save a copy of the SOE, select the **Print SOE/SOC** button. The document will open in a new window. Retain a copy of the SOE for your files and another copy for the subscriber.
3. Select the **Continue** button to review, upload any supporting documentation and approve the transaction.
 - a. If you need to edit a transaction, select Edit. Print the revised SOE

- with the barcode-signature sheet which requires signatures again.
- b. Review any required supporting documentation for the transaction.
This includes the signed barcode-signature sheet.
 - c. Add any supporting documents by dragging and dropping files to the web page or by selecting the **Add Docs** button.
 - d. Once the file or files are added, select the **Upload** button. The upload will show as complete. An error message will show if the file doesn't meet the upload requirements.

Select the **Approve** button once the legible file or files are uploaded. The option to print another barcode-signature sheet is available.

If you choose to mail the signed barcode-signature sheet and required supporting documentation to PEBA, please note the following:

- Place the signed barcode-signature sheet on top and staple any required supporting documentation.
- You may want to place a copy in the subscriber's file.

Do not delay in sending the signature page and barcode page. The subscriber's file is locked until the signed barcode-signature sheet is received, processed, and the transaction is applied by PEBA.

If entering enrollments electronically from a signed, paper NOE, be sure to double-check the data you entered against the NOE.

The transaction will be listed as Pending PEBA Approval on the Current EBS tab.

You can see the required supporting documents or view the submitted supporting documents before PEBA approves the transaction.

- From the Current EBS tab, select the transaction and then Continue.

- Under Supporting Documents, see the required supporting documents listed or view the submitted supporting documents by selecting the View button.

Once PEBA receives the signed barcode-signature sheet, along with any required documentation, the transaction will be applied and will no longer appear on the Current EBS tab.

If you apply the transaction to MyBenefits, an electronic SOE is sent to the employee's MyBenefits account.

Notify the employee to log in to MyBenefits, review the transaction, electronically sign it to complete it, and upload any supporting documentation, if needed. If there is an error, he can return the transaction to you through MyBenefits for correction. If the subscriber does not upload the supporting documentation, remind him to provide the documentation to you. You can either upload the documentation through EBS or mail it to PEBA.

The transaction will appear on the BA Console under the Approval tab, waiting for the subscriber to approve it.

The subscriber must log into MyBenefits and review the transaction.

- If the subscriber is a first-time user of MyBenefits, he must first complete the registration process.
- Once the subscriber is logged in, the pending transaction will appear immediately.
- The subscriber may select the transaction to review and then choose to Approve or Return the transaction.

Once approved, the subscriber can upload any required documentation.

- *If no documentation is required,* the transaction will move from the Approval tab to the Acknowledgement tab on the BA Console. PEBA records will be updated automatically. Once you acknowledge the

transaction, you can print a copy of the SOE for the employee's file, or, if you maintain personnel records electronically, you can save the SOE as a PDF file. The SOE will be electronically imaged into PEBA's imaging system. No documents need to be mailed to PEBA.

- *If documentation is required*, you must notify the subscriber and remind him to provide the required documentation promptly; otherwise the transaction cannot be completed. The transaction will remain on the Approval tab on the BA Console with a Yes for Supp. Docs, and a status of Pending Employer Approval. When you receive the documentation, you may then upload the documents. Approve the transaction.
- *If the subscriber uploaded the required documentation*, you must review the transaction and documents. If needed, upload additional documents or delete (explanation required). Select Continue on the transaction and after your review, select Approve. No documents need to be mailed to PEBA.

If the subscriber returns the transaction due to an error or change, the transaction will remain on the Approval tab, but the status changes to Subscriber Returned. You can then edit and resubmit the transaction to return it to the subscriber for approval, or you can delete it, thereby canceling the transaction.

Changes

You may process most family status changes using EBS. The system is designed to assist in the process by providing policy-driven edits. Choices and elections are restricted, based on the reason(s) for change selected initially. Certain change reasons will result in some fields being populated automatically. Other fields and tabs will be hidden or grayed out.

The effective dates are calculated automatically based on the information entered on the Define Your Change screen. A summary of the changes can be viewed on the Review tab and on the Summary of Change (SOC).

Required documentation notices are based on the change reason and/or the spouse or child(ren)'s eligibility status and can be uploaded through MyBenefits or EBS.

Make changes to current subscriber(s).

- From Manage Subscribers, select Change from the drop-down list.
- Enter the subscriber's SSN.
- Select Go.
- Select the Reason for Change from the drop-down list. The reasons are listed in most frequently used order.
- You will be prompted to enter a sub-reason from the drop-down list, if applicable.
- The current date is the default date; update the date, if necessary.
- The reason and/or sub-reason will generate instructions and basic requirements, as applicable.
- If the change is due to a special eligibility situation, a new field, Date of Request, will sometimes appear. The Date of Request field is automatically filled with the current date. Adjust this date only if you are keying the transaction from an NOE that an employee signed on a different date. For example, if the reason selected is Marriage, the system will request the date of marriage, the date of request and will include a note stating that the request must be made within 31 days of the date of marriage.
- Select Next.

The Enrollee Data tab will then appear.

Enrollee Data tab

The Enrollee Data information (address, phone numbers, email address, spelling of name) may be updated with any change type.

- Address changes processed using the Current EBS method require both the subscriber and the benefits administrator signatures.
- Changes to the subscriber's SSN or date of birth must be made on a paper Notice of Election (NOE). Supporting documentation must be attached to the NOE.

Select Next to move to the Dependents tab.

Dependents tab

You may change the status of the coverage for the existing spouse and children, based on the change reason.

- **Ineligible dependent child(ren)** Selecting ineligible terminates all coverage benefits for the child(ren).
- **Dependent deceased** The Deceased button terminates all coverage benefits for the deceased spouse or child(ren).
- **Dependent gain of other coverage** (state or non-state)
 - Use the drop-down list to *terminate only those benefits gained elsewhere*.
- **Dependent loss of other coverage** (state or non-state)
 - Use the drop-down list to add only those benefits lost elsewhere. Loss of state benefits for a spouse will allow adding Dependent Life-Spouse coverage.
- **Family status changes** Previously covered child(ren) may be chosen from the Reactivate Dependent List and their benefits activated.

Select Next to move to the Coverage tab (if applicable).

Coverage tab

Based on the change reason, fields will be populated automatically on the Coverage tab. Only those fields with a white background may be edited.

- **Marriage, newborn, adoption, custody** – Optional Life benefits may be selected or increased, and a new coverage level may be chosen from the drop-down menu where the maximum amount available without evidence of insurability is displayed.
- **Elections or increases of Optional Life coverage levels with evidence of insurability:**
 - A *Statement of Health* form must be completed and sent to MetLife for review.
 - *For those who are MoneyPlus participants* – action must be requested within 31 days of a family status change or during enrollment periods in which participants can select or increase coverage, without evidence of insurability, above the amount available. Approvals from MetLife should be forwarded directly to PEBA with an NOE and supporting documentation.
 - *For those who are not MoneyPlus participants* – requests may be processed through EBS and forwarded to PEBA with the SOC, approval letter from MetLife and supporting documentation. These requests may be made throughout the year.

Select Next to move to the Beneficiaries tab (if applicable).

Beneficiaries tab

Based on the change reason, make changes as needed. Use the Delete button to remove a beneficiary.

If the desired beneficiary is a spouse or child(ren) listed on the Dependents tab, press Add beside Add from existing dependent list. Select the dependents from the list and select Add Selected Dependents to Beneficiaries. The personal information and relationship of the dependent(s) will populate automatically.

To add more beneficiaries, select the number of beneficiaries from the drop-down list and click Add.

Complete the required beneficiary information, indicate the life insurance program by clicking on the box beside the elected programs, indicate the percentage if not equally divided among the beneficiaries, and select Primary or Contingent from the drop-down list.

Select Next to move to the Review tab.

Review tab

The Review tab is a complete list of all information entered on the previous tabs. The type of action taken and the effective date will be at the top of the page.

From this page you may return to any tab by selecting on the tab at the top of the page if adjustments to the information are needed.

The **Summary of Change (SOC)** is a complete list of the subscriber's elected benefits, ID data, spouse and child(ren) information and beneficiary information.

The change reason will be shown at the top of the form. The effective date of the transaction will also be shown at the top, along with a description of any documentation that may be required.

Both the old values and the new values, created by the transaction, will be displayed.

You may Suspend, Cancel or Apply the transaction by selecting the desired button (top right of page).

- **Suspend** will allow you to keep what has already been processed, and you may retrieve it at a later date. It will be on the Suspended tab of the BA Console and will

be listed as Incomplete. You will receive a SUSPEND message box, inside which you enter the reason for suspending the file.

- **Cancel** will remove the entire transaction. Once you confirm cancellation, it cannot be recovered.
- **Apply** the transaction and choose either Current EBS to generate a paper SOE or MyBenefits (see Page 15) to generate a paperless SOC. Selecting MyBenefits allows the employee the option to upload required documentation.

If you apply the transaction to Current EBS, a printed SOC must be signed by the benefits administrator and the subscriber within 31 days and sent or uploaded to PEBA.

An address change processed through the Current EBS method requires both the subscriber and the benefits administrator signatures.

If you apply the transaction to MyBenefits, an electronic SOC is sent to the employee's MyBenefits account. See Page 15 for more information on this process.

Termination

You may process most terminations using EBS.

Unlike the enrollment and change processes, terminations are entered directly into the PEBA system without going through the suspense process. PEBA's insurance files are updated immediately for billing and transmission to the carriers.

Some types of terminations must still be sent to PEBA for processing, including terminations with an effective date that is more than 31 days past.

- Under Manage Subscribers, select Terminate from the drop-down list.
- Enter the subscriber's SSN.
- Select Go.

The Terminate Coverage tab will then appear.

Terminate Coverage tab

- Select the Reason for Termination from the drop-down list.
- Enter the effective date.
- Enter any additional information if prompted to do so.

Select Next to move to the Review tab.

Review tab

The Review tab will include status and effective date changes. It also will have reminders about COBRA notification, continuation, conversion and MoneyPlus. Mark any applicable items.

- Select Apply to complete the termination.
- Reprint the Summary of Termination (SOT), if needed for your files and for the subscriber. The termination form will be electronically imaged into PEBA's imaging system. No documents need to be mailed to PEBA.

Manual transactions

Although you can enroll subscribers and/or change their enrollment and personal information, there are some transactions that must be processed manually, using a paper *Notice of Election* (NOE).

Enrollments/re-enrollments

- Retirees returning to work for a participating employer.
- NOEs from new hires, changing their minds within 31 days, if the first request has already been applied by PEBA.
- Open enrollment changes that may require two transactions (such as family status changes with effective dates in October, November or December).

Changes

- Social Security numbers; or
- Dates of birth.

Dependents

- Adding incapacitated children.

Terminations

- Terminations due to military leave;
- Terminations of coverage when Supplemental Long Term Disability is in a waiver of premium status; or
- Terminations effective more than 31 days retroactive.

Administrative approvals

- Including those for effective dates that are more than three months retroactive.

MyBenefits

MyBenefits allows subscribers of participating employers to access their insurance information using the internet and to make some changes on their own. MyBenefits is also paperless and allows subscribers to upload supporting documentation.

Changes made using MyBenefits are sent electronically to PEBA, and you can view these changes through EBS.

When contact or beneficiary information is changed, you will receive an acknowledgement notice through the EBS BA Console.

During open enrollment, *your subscribers can make their own coverage changes* for the next year. Depending on the type of change an employee makes, you will receive an approval notice on the BA Console.

A step-by-step flyer on how to register for MyBenefits can be found at www.peba.sc.gov/assets/mybenefitsflyer.pdf.

Using MyBenefits

After logging in, the subscriber will see any transactions you submit for his approval or he may choose:

- **Review Benefits** To see his benefits. He may print them, but he cannot change any of the information in the Review Benefits view.

- **Contact Information** To review his address, phone numbers, and email address and update them.
- **Change** The subscriber can initiate or approve changes made as a result of a special eligibility situation.
- **Beneficiary** To review and change his beneficiaries.
- **Open Enrollment** The subscriber can make changes during the fall enrollment period.

When a subscriber makes a change using MyBenefits, a Summary of Change (SOC) will be generated, similar to what's generated in EBS. Only changes and updated information will appear in the New Value fields on the right side of the SOC.

- To accept the change(s), the subscriber selects the Approve button.
- A certification, authorization and disclaimer statements appear, which require an electronic signature. The subscriber then enters the last four digits of his SSN for the electronic signature. This authorizes and processes the transaction/change.

A final SOC is generated that the subscriber can print for his records.

Making special eligibility changes

Subscribers can make changes using MyBenefits when a special eligibility situation occurs, such as adding a newborn, marriage, divorce or adoption. MyBenefits will display the documentation required for each change. The required documents can be uploaded through MyBenefits.

Making open enrollment changes

During open enrollment, your subscribers can make their own coverage changes in MyBenefits.

Your Current Coverage

This section shows the subscriber's coverage and coverage levels.

Make Coverage Changes

In this section, the subscriber can enroll, change and cancel coverage for the various programs based on the changes allowed during the enrollment period. Built-in edits prevent the subscriber from enrolling in a program for which he, his spouse or his child(ren) is not eligible or from selecting a level of coverage above what is allowable.

Dependents

In this section, the subscriber can review his spouse and/or child(ren) and their coverage, add a spouse and/or child(ren) or add or cancel coverage for his spouse and/or each child by program (health, dental, vision, Dependent Life), based on the options allowed during the enrollment period.

Beneficiaries

This section shows the subscriber's current beneficiaries. Here, he can add or delete beneficiaries, designate them as primary or contingent and change the percentages they would receive for Basic Life and Optional Life.

Completing open enrollment changes

Once subscribers have completed their enrollment changes, they will be prompted to review the screen before electronically authorizing and submitting those changes. A Summary of Intent (SOI) is generated that the subscriber can print for his records. The enrollment change data will then be sent to the BA Console in EBS for review and approval.

If the subscriber changes his mind during enrollment

If a subscriber changes his mind about his elections:

- The subscriber may go into MyBenefits and edit and/or delete his enrollment changes until 11:59 p.m. October 31, regardless of whether the transaction has been approved by the employer. If the employer has approved a previous transaction, a new status will appear on the Approval tab of

the BA Console as Pending Employer Approval-Subscriber Changed.

The deadline for all open enrollment changes is October 31.

BA Console

The BA Console in EBS consists of four tabs: the Suspended tab, Acknowledgement tab, Approval tab, and Current EBS tab. From the BA Console, follow up on transactions initiated by you in EBS, as well as transactions initiated by subscribers in MyBenefits.

You can change the number of transactions displayed on the tabs — 10, 25, 50 or 100.

Suspended tab

The Suspended tab shows transactions that have been suspended by the employer and are in an **Incomplete** status. You can suspend a transaction for any number of reasons. For example, you are waiting for needed documentation, the transaction has not been completely processed, etc.

Incomplete transactions may be edited or deleted. Select anywhere on the row of a transaction to open it.

- **Edit** allows you to make changes or corrections to the subscriber's data. Once you have made changes, review them and then apply them to generate a revised SOC. This revised SOC must be submitted to PEBA, along with any required documentation. If you edit a transaction prior to approving, another signature page and/or barcode page must be submitted to PEBA. The latest edited transaction must be signed and dated by you and the subscriber before submitting to PEBA.
- **Delete** removes the transaction. Deleting a transaction before it is applied by PEBA will cancel the transaction, and it will disappear from the Suspended tab.

Transactions more than 31 days old are highlighted in yellow.

The status will change from Incomplete to Complete and move to the Approval tab or Current EBS tab for completion once you finish processing the transaction.

At 60 days, a suspended transaction is canceled automatically, and is deleted. The transaction is not applied. If the transaction is still valid, you need to send a [Request for Review Form](#) to PEBA.

Acknowledgement tab

The Acknowledgement tab shows transactions that are initiated by the subscriber using MyBenefits or initiated by you and sent to the subscriber to approve electronically in MyBenefits. These transactions do not require documentation. Examples include:

- Contact information (address, phone numbers, email address) changes;
- Beneficiary changes; and
- New hire enrollments that do not require any documentation.

Select anywhere on the row of a transaction to open it. When you acknowledge the transaction, a new window opens with the SOE/SOC. You may print copies or save them electronically. No documents need to be mailed to PEBA.

Transactions more than 31 days old are highlighted in yellow.

Transactions that are 60 days old are removed from the Acknowledgement tab automatically. However, these transactions were applied at the time the subscribers made them.

Acknowledging these transactions will remove them from the Acknowledgement tab. Notify any other applicable parties of the address changes.

Approval tab

The Approval tab shows transactions that are initiated by subscribers using MyBenefits or

initiated by you and sent to the subscriber to approve electronically in MyBenefits.

Print a copy or save the SOEs/SOCs for the subscribers' files and update payroll files as needed. These changes are not applied by PEBA or sent to the third-party claims processors until after you approve them.

You must process (or reject) these transactions in time to allow your subscribers to correct their changes or to change their minds (either through MyBenefits or by completing a paper *Notice of Election*) before the end of the enrollment period on October 31 or a 31-day election period.

The Status (third column) and Support Documents (fourth column) information is vital in handling these transactions.

Records that have been rejected by PEBA are highlighted in green and appear at the top of the list for your immediate attention.

Transactions more than 31 days old are highlighted in yellow.

At 60 days, a pending transaction is canceled automatically, and is deleted. The transaction is not applied.

Current EBS tab

The Current EBS tab shows transactions that are initiated by you and printed for signatures.

After selecting a transaction, select Print Signature Sheet to print the barcode-signature sheet. Select Print SOE/SOC or save any copies of the SOE/SOC you need for your files or for the employee. Select Edit to make any necessary changes.

Select Continue to review, upload any supporting documentation and approve the transaction. Once you approve a transaction, PEBA's files are updated and a copy of the SOE/SOC is imaged at PEBA. The benefits administrator and subscriber are required to sign and date the signature page.

Either upload all documents, including the signed barcode-signature sheet, or print and mail all documents with barcode to PEBA. If uploading, do not mail the documents to PEBA.

Status

The nine possible statuses are explained below.

Pending Subscriber Approval. No documentation required.

- This indicates transactions you initiated and sent to the subscriber to approve electronically in MyBenefits.
- Notify the subscriber to log into his MyBenefits account, review the pending transaction, and electronically sign the SOE/SOC.
- Once approved by the subscriber, the transaction will move to the Acknowledgement Tab on the BA Console.
- The transaction will update PEBA's records when the subscriber signs the transaction in MyBenefits.

Pending Subscriber Approval. Documentation required.

- This indicates transactions that you initiated and sent to the subscriber to approve electronically in MyBenefits.
- Notify the subscriber to log into his MyBenefits account, review the pending transaction, and electronically sign the SOE/SOC.
- The subscriber can upload any required documentation in MyBenefits.
- Once approved by the subscriber, the transaction will move to the Approval tab on the BA Console and show as Pending BA Approval.

Pending Employer Approval. No documentation required.

- Select Continue to review, upload any supporting documentation and approve the transaction.

- Your electronic approval updates the file automatically at PEBA and sends a copy of the transaction to the appropriate third-party claims processors.
- The delete button removes the transaction completely. All changes made by the subscriber are canceled.

Pending Employer Approval.

Documentation required.

- Select Continue to review, upload any supporting documentation and approve the transaction. You must also review any uploaded documentation. If the subscriber provides you with the documentation, upload the documents.
- If the required documentation was not uploaded to PEBA, a barcode page will be generated. Print and send only this barcode page with the documentation attached to PEBA. Do NOT send a copy of the SOE/SOC to PEBA.
- The status will change to Pending PEBA Approval. When PEBA reviews the documentation, the transaction will be applied, if correct.

Pending PEBA Approval.

- This indicates transactions you have already approved and for which you have submitted the supporting documentation to PEBA.
- You will have the option to review and print a copy of the SOEs/SOCs until PEBA approves the transaction.
- These transactions will disappear from the BA Console when PEBA verifies the supporting documentation. If the documentation submitted is not complete or sufficient, PEBA will reject or remove the transaction.

Subscriber Returned. Documentation may or may not be required.

- This indicates transactions that you initiated and sent to the subscriber to approve

electronically in MyBenefits; however the subscriber returned the transaction to you because of an error or change.

- View the transaction and read the subscriber's note to find out what correction(s) he is requesting.
- Edit the transaction and send it back to the subscriber to review and approve in MyBenefits.
- Select Review to view and print a copy of the SOE/SOC without making any changes to the document.
- After review, select Approve.
- Your electronic approval updates the file automatically at PEBA and sends a copy of the transaction to the appropriate third-party claims processors.
- Select Delete to remove the transaction completely. You may go back into EBS and initiate a new transaction.

PEBA Rejected.

- This indicates transactions that PEBA has returned to the BA Console because the supporting documentation was not complete or not sufficient.
- These transactions will be highlighted in green at the top of the Approval tab.
- Select the transaction to view the reason for the rejection.
- Obtain the additional or corrected documentation. You may also need a copy of the original SOE/SOC as verification of the date the subscriber initially tried to make the change.
- Once you receive the new/corrected documentation, approve the transaction. The status will change back to Pending PEBA Approval.
- Print the new barcode page, attach the new documentation and mail to PEBA or upload documentation.
- If you determine that the transaction is not valid, you can delete the transaction.

Pending Employer Review-Print.

Documentation required.

- This indicates transactions you initiated using the Current EBS method.
- Select the transaction and Review/Print to print any copies you need for your records or for the subscriber.
- If the subscriber reviews the transaction and wants to make a change, select Edit.
- If you determine that the transaction is not valid, you can delete the transaction.
- After the subscriber has reviewed and approved the transaction, select Approve.
- The transaction will update PEBA's records, and a PDF file will open containing a signature page and/or barcode page. These two pages, along with supporting documentation, must be mailed to PEBA.

Pending Employer Review-Print. No documentation is required.

- This indicates transactions you initiated using the Current EBS method.
- Select the transaction and Review/Print to print any copies you need for your records or for the subscriber.
- If the subscriber reviews the transaction and wants to make a change, select Edit.
- If you determine that the transaction is not valid, you can delete the transaction.
- After the subscriber has reviewed and approved the transaction, select Approve.
- The transaction will update PEBA's records, and a PDF file will open containing a signature page and/or barcode page. These two pages must be mailed to PEBA.

Tips

- If you need to print an SOE or SOC but do not see it on your screen after you apply the transaction, check the bottom toolbar or behind other windows on your screen. Sometimes the document will minimize.

- You can reprint SOEs and SOC's initiated in MyBenefits. Under Manage Subscribers, select Subscriber SOC's and enter the subscriber's SSN. Select Go. Select the PDF file under the SOC column to view it.
- Upload signature pages and/or barcode pages to PEBA as soon as possible, so the transactions can be applied. If the employee is not available to sign the SOE/SOC, have him complete and sign a *Notice of Election* (NOE) and attach it to the SOE/SOC.
- Do not write additional instructions on an SOC; PEBA cannot key handwritten changes. Re-enter the transaction in EBS.
- Notify your payroll department of any changes that affect premiums.
- Print copies of any transactions that are rejected by you or PEBA and notify the subscriber.
- If a *Notice of Election* (NOE) is required because of a rejection, attach a copy of the original SOE/SOC to the NOE. This will verify the original requests for enrollment, change or open enrollment transactions were made within 31 days.

SLTD salary updates using EBS

To update SLTD premiums correctly for the next plan year, PEBA needs updated salary information for your employees who are enrolled in SLTD. The salary on which SLTD premiums are based should include the employee's base rate of pay for the hours they are regularly scheduled to work, plus any of the following that apply to the employee:

- Longevity pay;
- Shift differential pay;
- Regular compensation earned by university teaching staff during regular summer sessions; or
- Contributions the employee makes to deferred compensation plans or fringe benefits (like payroll deductions for health insurance).

Do not include overtime pay, commissions, bonuses, employer contributions to benefits, or any other extra compensation.

If your employer is not a part of the Comptroller General (CG) payroll, submit your updated salaries as of October 1.

You may begin entering the salaries in EBS on September 15. Please submit this information to PEBA no later than October 31.

You should include data for those who have had a salary change since the previous October 1.

- *Example:* If an employee was hired March 2014 with a salary of \$25,000, and he has received a salary increase of \$3,000, and his salary as of October 1 includes this increase, you must submit this updated salary.
- The maximum annual salary for calculating SLTD benefits and premiums is \$147,684. If PEBA receives any salary updates that exceed this amount, the amount entered into the system will default to \$147,684.
- Employers affected by furloughs should use employees' non-furlough salaries to calculate premiums.

View the SLTD tutorial video at www.peba.sc.gov/itrainingresources.html.

In EBS, select SLTD Salary Entry under Manage Groups. Use one of the methods listed below:

- Select SLTD Salary Browse to add employee salaries individually. Enter the data into each field and click on the button at the bottom of the screen to submit the information for each employee.
- Upload SLTD data text file.
- Download SLTD Coverage Data. This list includes all employees enrolled in SLTD at the time of your request. Follow the instructions to create a new text document, and then select Upload SLTD Data to upload your revised file to EBS.

- Select the Batch Entry Screen, which allows you to enter 10 employee salaries at a time.

Select Current SLTD Coverage List to receive a list of all employees currently enrolled in SLTD. Review and Confirm all SLTD salary entries when you have completed updates for your employer.

If you have any questions, contact Chuck Wilson, operations manager for insurance benefits, at chuck.wilson@peba.sc.gov or 803.734.1787.



Active subscribers

Active subscribers

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Employee eligibility rules and procedures

The Plan of Benefits defines an employee as:

A person employed by an Employer on a Full-Time basis, and who receives compensation from a department, agency, board, commission or institution of the State, including clerical and administrative Employees of the General Assembly, and judges in the State courts. For purposes of this Plan, the term shall include other Employees that the General Assembly has made eligible for coverage by law, including Employees of a public school district, county, municipality, or other State-Covered Entity that has qualified for and is participating in, coverage under the Plan. The members of the South Carolina General Assembly and elected members of the councils of participating counties or municipalities, whose council members are eligible to participate in the South Carolina Retirement Systems, and Part-Time Teachers, are also Employees for purposes of the Plan.

The Plan of Benefits defines full-time:

With regard to an Employee shall mean an employee who is credited with an average of at least 30 hours of service per week. Provided, however, an employer may exercise a one-time, irrevocable option to elect the definition of Full-Time to mean an employee who is credited with an average of at least 20 hours per week, and to apply this definition, upon notification and acceptance by PEBA. Full-time status for purposes of eligibility to participate in the Plan is determined in accordance with the process set out in paragraphs 3.19, 3.20, and 3.21 of the Plan.

Determining eligibility for benefits

The Affordable Care Act (ACA) requires all Applicable Large Employers to offer health insurance that is affordable and provides minimum

value to all full-time employees or pay a penalty to the IRS.

To accommodate this requirement, participating employers must offer coverage to any employee who meets the eligibility requirements established by the ACA.

All employees fall into one of three categories:

- New full-time employee (Permanent or Nonpermanent) – A newly hired employee who was determined by the employer, as of the date of hire, to be full-time and eligible for benefits. The employee is eligible to enroll in coverage within 31 days of his hire date.
- New variable-hour, part-time or seasonal employee – A newly hired employee who is not expected to be credited an average of 30 hours per week for the entire measurement period, as of the date of hire. Therefore, the employer cannot reasonably determine his eligibility for benefits as of the date of hire. The employer must measure the employee's hours to determine whether the employee will be eligible for benefits.
- Ongoing employee - Any employee who has worked with an employer for an entire Standard Measurement Period (see below).

To assist employers with determining an employee's eligibility for benefits, the IRS has established three safe harbor regulations: Measurement Periods, Administrative Periods and Stability Periods.

Measurement periods

A measurement period is the period of time an employer uses to review the number of hours worked by an employee to determine eligibility for benefits.

There are two types of measurement periods: **Initial Measurement Period** and **Standard Measurement Period**.

An **Initial Measurement Period** applies to any newly hired variable-hour, part-time or seasonal employee. An Initial Measurement Period begins the first of the month after the date of hire and ends 12 months later. The employer would not offer benefits to a newly hired variable-hour, part-time or seasonal employee at the time of hire, instead the employer would review the employee's hours over the Initial Measurement Period to determine eligibility.

The **Standard Measurement Period** applies to all ongoing employees and begins on October 4 of each calendar year and ends on October 3 of the next calendar year. For Plan Year 2020, the Standard Measurement Period runs from October 4, 2019, and ends on October 3, 2020.

Administrative periods

The Administrative Period is the period of time (immediately after the measurement period) when the employer notifies an employee of his eligibility for benefits and the plan processes the employee's enrollment.

There are two types of administrative periods.

Initial Administrative Period

A new variable-hour, part-time or seasonal employee credited with an average of 30 hours per week during his Initial Measurement Period may enroll during an Initial Administrative Period, which begins the day after the end of his Initial Measurement Period and ends the last day of the same month. Coverage begins the first of the month after the end of the Initial Administrative Period.

Standard Administrative Period

The ACA requires employers to monitor the hours of all employees to ensure eligible employees are offered benefits. An ongoing employee credited with an average of 30 hours per week during the Standard Measurement Period may enroll annually during the October enrollment period with coverage effective January 1.

The Standard Administrative Period for plan year 2020 is October 3, 2019 to December 31, 2020. Employers must offer coverage to eligible employees during the plan's open enrollment period, which ends October 31, 2020. All enrollments must be submitted to PEBA according to the open enrollment submission deadline (refer to Page 23 open enrollment). PEBA will use the remainder of the Standard Administrative Period to process enrollments to ensure employees have access to coverage at the beginning of the Stability Period (January 1, 2020).

The Standard Administrative Period is also the period of time an employer must notify an employee of his loss of eligibility for the next plan year. If an eligible employee is not credited with an average of 30 hours per week during the Standard Measurement Period, the employee will lose eligibility at the end of his stability period.

- If the employee is an ongoing employee and he does not qualify for benefits in the next plan year, the employee will lose eligibility at the end of the current plan year. The employer should:
 - Notify the employee he will not be eligible for benefits in the next plan year.
 - If the employee is enrolled in health, dental or vision, send the employee and his covered dependents an 18-month COBRA Notice. The COBRA Qualifying Event will be the employee's reduction of hours effective January 1.
 - Submit the termination in EBS or send the Active Termination form and check box T5—Not Eligible (Not in stability period).
- If the employee is a new variable-hour, part-time or seasonal employee and he does not qualify for benefits based on the Standard Measurement Period, the employee will lose eligibility at the end of his Initial Stability Period. During the

Standard Administrative Period, the employer should notify the employee he will not be eligible for benefits when his Initial Stability Period ends. At the end of the employee's Initial Stability Period, the employer should:

- Notify the employee of his loss of eligibility.
- If the employee is enrolled in health, dental or vision, send the employee and his covered dependents an 18-month COBRA Notice. The COBRA Qualifying Event will be the employee's reduction of hours effective the end of his Initial Stability Period.
- Submit the termination in EBS or send the Active Termination form and check box T5.

Stability periods

The Stability Period is the period of time an employee remains eligible, regardless of the number of hours worked.

An Initial Stability Period for New Variable Hour, Part-Time and Seasonal Employees begins the first of the calendar month after the end of the Initial Administrative Period and ends the day before in the following calendar year. For example, an Initial Stability Period that begins on May 1 of one year would last until April 30 of the following calendar year.

A Standard Stability Period for Ongoing Employees begins January 1 of each year and ends on the following December 31.

Notes on employee eligibility

- An employee who returns to the same employer with no break in coverage or with no more than a 15-calendar-day break in employment is considered a transfer, not a new hire. For a break in service of greater than 15 calendar days, but less than 13 calendar weeks (26 weeks for academic

employers), see the [Affordable Care Act Reporting Requirements Frequently Asked Questions](#).

- An academic employee (public school districts, universities, colleges and technical colleges) who completes a school term and moves to another academic setting with another participating academic employer at the beginning of the next school term is a transfer, not a new hire.
- Eligibility for benefits is based on the number of hours the employee works for an employer. If an employee works for more than one participating entity that shares a common payroll center (i.e., CG agencies), the hours worked for both agencies should be combined to determine eligibility. In the case of a tie, both employers should offer coverage, the employee can choose from which employer to accept coverage. See the [Affordable Care Act Reporting Requirements Frequently Asked Questions](#).
- An employee who works for two participating employers is considered working for one employer or the other employer for insurance purposes. His insurance coverage and premiums *cannot* be split between the two employers, nor may he combine his two salaries for Optional Life/Dependent Life Insurance purposes. See Page 67, Transfers and Terminations, for additional information.
- There are other special provisions regarding calculating hours of service and eligibility for benefits, especially for academic employers. PEBA strongly encourages employers to consult with their legal counsel for guidance in calculating hours of service.

Active nonpermanent full-time employees are eligible for the same insurance benefits as active permanent full-time employees. They are enrolled in benefits using an Active NOE, not a Part-time NOE. In the Eligible due to the

Affordable Care Act box on the Active NOE, check Full-time nonpermanent.

While nonpermanent full-time employees are eligible for active employee insurance benefits, they may not be eligible for retiree coverage if they retire from a nonpermanent position. See Page 89 for retiree eligibility requirements, including that the last five years of active employment must be full-time, permanent and consecutive.

Note: PEBA does not verify the eligibility of employees for employers. Neither does it classify employees.

Procedures to elect 20-hour threshold

Any participating employer has the option of reducing the threshold for insurance eligibility for all full-time employees from 30 hours per week to at least 20 hours per week.

- To elect the 20-hour threshold, the director/head of the participating employer must send a letter to PEBA requesting this option. The letter should acknowledge the guidelines below. The director/head must sign the letter, and the original should be sent to the Operations manager at PEBA (address on Page 9).
- PEBA will send back a letter acknowledging receipt of the request. This letter will restate the guidelines below and will include the date the change to 20 hours will go into effect.

Guidelines for extending benefits to 20-hour employees

- Benefits must be offered to **all** employees working 20 or more hours per week.
- The decision to extend benefits to employees working 20 or more hours per week is **irrevocable**.
- Employees working 20 or more hours per week are entitled to participate in the same

state benefits available to other full-time employees.

- The minimum employer contribution for these employees is the same as for other full-time employees.

Assisting a benefits-eligible employee

Prepare an information packet as outlined below. Use the Newly Employee Checklist on Page 187 to ensure that you have covered all benefit information.

Required information

When an employee becomes eligible for insurance benefits, provide the employee with the following items (all of these items are available online at www.peba.sc.gov/newemployees.html):

- [Federally mandated notices](#);
- [Insurance Summary](#);
- [New Hires: Enrollment is Easy with MyBenefits](#) flyer;
- [MyBenefits registration instructions](#) flyer;
- [Marketplace Exchange Notice](#) (under the ACA heading); and
- [Notice of Special Enrollment Rights](#) (under Other forms heading).

If enrolling on paper, provide:

- [Active Notice of Election](#) (NOE); and
- [Certification Regarding Tobacco or E-cigarette Use](#).

Review benefits available

Explain the following benefits are available to all eligible employees. The new employee must choose or refuse one or all of the following, based on eligibility:

Health insurance

State Health Plan (includes prescription drugs and mental health/substance use; includes an additional preventive benefit for Savings Plan).

Subscribers of the State Health Plan are also eligible for [PEBA Perks](#), value-based benefits at no cost.

Explain the premium for tobacco or e-cigarette users which is automatic for State Health Plan subscribers, unless subscriber certifies he nor anyone he covers uses tobacco or e-cigarettes or covered individuals who use tobacco or e-cigarettes have completed a tobacco cessation program approved by PEBA. See Page 36 for more information.

GEA TRICARE Supplement Plan is available to members of the military community.

Dental insurance

- Dental Plus; or
- Basic Dental.

Vision care

- State Vision Plan.

Life insurance

Automatic enrollment in Basic Life with AD&D at no cost if enrolled in health insurance.

- Optional Life with AD&D;
- Dependent Life-Spouse with AD&D; or
- Dependent Life-Child (a child ages 19-24 must be a full-time student or certified as incapacitated to be eligible for coverage; a child older than 24 must be certified as incapacitated to be eligible for coverage).

Long term disability insurance

Automatic enrollment in Basic Long Term Disability (BLTD at no cost if enrolled in health insurance).

- Supplemental Long Term Disability (SLTD).

There is a 12-month pre-existing condition exclusion period related to BLTD and SLTD benefits.

Any applicable late entrant procedures and the preexisting exclusion period is 12 months for late entrants to SLTD.

MoneyPlus

- Pretax Group Insurance Premium feature for health (with or without tobacco use premium), Dental Plus, Basic Dental, State Vision Plan and up to \$50,000 in Optional Life coverage.
- Medical Spending Account (MSA).
- Limited-use Medical Spending Account.
- Dependent Care Spending Account (DCSA).
- Health Savings Account (HSA).

Review network, preauthorization, claims requirements

Explain the State Health Plan requirements for Medi-Call, mental health and substance use benefits, maternity management benefits, Pap Test benefit, advanced radiology scans (such as, but not limited to, CT, MRI, MRA, PET scans), the hospital and physician networks, the Prescription Drug Program networks and the well child benefit.

Explain the claims processing steps for benefits, including how to file manual claims, and that completed claim forms should be submitted as services are rendered. Forms are also available on the PEBA website at www.peba.sc.gov/iforms.html.

Explain how to request reimbursements from MoneyPlus accounts for unreimbursed expenses.

Refusal of coverage

An employee may refuse to enroll in any or all of the benefits plans offered by the state. **If an employee refuses health coverage, he forfeits Basic Life and Basic Long Term Disability coverage.**

To refuse coverage, an enrollment indicating **Refuse** must be submitted to PEBA.

If an employee is already enrolled as a dependent on his parent's coverage through PEBA, he may

continue coverage as a dependent or enroll in coverage as an active employee. If the employee chooses to remain enrolled as a dependent, he may not enroll in any benefits as an employee, including SLTD and Optional Life.

- The benefits administrator should have the employee complete and sign a paper NOE refusing all coverage. Under Type of Change on the NOE, next to Other, specify *Enrolled as child of PEBA subscriber*.

Explain enrollment deadlines

Enrollments must be completed and signed within 31 days of date of hire or a special eligibility situation (birth, marriage, adoption or placement for adoption, or loss of coverage).

If not completed within 31 days, wait until the next open enrollment period or a special eligibility situation to enroll in health, dental and/or vision coverage. Full-time employees must provide evidence of insurability to enroll in Optional Life and Dependent Life-Spouse and medical evidence of good health to enroll in SLTD coverage.

The new employee is allowed to change his mind about an original selection within 31 calendar days of his date of hire (*not* the effective date of coverage). To make a new selection, a paper NOE must be signed within the 31-day window and submitted to PEBA for processing. Indicate on the NOE that it is a revision within 31 calendar days.

Explain effective dates

New full-time employees

If the employee's first scheduled workday is the *first calendar day* of the month, coverage begins that day (on the first of the month).

If the employee's first scheduled workday is the *first working day* of the month (first day of the month that is not a Saturday, Sunday or observed holiday), but not on the *first calendar day* of the month (for example, he begins on the 2nd or 3rd of the month), then the employee may choose when coverage begins:

- The first day of that month, or
- The first day of the following month.

If the employee's first scheduled workday is *after the first calendar day and after the first working day of the month* (after the first day that is not a Saturday, Sunday or observed holiday), coverage will begin the first day of the *following* month.

Coverage of the spouse and/or children will become effective when the new employee's coverage becomes effective.

Life insurance coverage is subject to the Dependent Non-confinement Provision, as well as the Actively at Work requirement.

Explain any applicable late entrant procedures, open enrollment and special eligibility situations.

- Dental Plus or Basic Dental. The carrier mails Dental Plus ID cards, with BINs printed on them, directly to subscribers.

Tobacco certification

To avoid paying the tobacco-use premium, new employees must certify that neither they nor their covered spouse and/or children use tobacco products or electronic cigarettes. The tobacco-use premium may also be waived if a tobacco user completes a tobacco cessation program through the State Health Plan's Quit For Life program.

- If completing a paper *Notice of Election* (NOE), also complete and attach a [*Certification Regarding Tobacco and E-Cigarette Use*](#) form before sending to PEBA for processing. The effective date for the waiver (or premiums if certifying as tobacco or e-cigarette user) will be the effective date of coverage on the NOE.

If the Certification form is NOT attached to the NOE and is sent later, the effective date for the waiver (or premium if certifying as tobacco or e-cigarette user) will be the first of the month after PEBA receives the form.

- If completing a paperless enrollment through MyBenefits or Current EBS, the Tobacco Coverage certification is submitted with the enrollment. The Certification form is not required. The effective date for the waiver (or premium if certifying as tobacco or e-cigarette user) will be the effective date of coverage on the enrollment.
- Subscribers may also follow up and certify later by completing the Certification form and submitting it to the benefits administrator to sign and forward to PEBA. The effective date for the waiver (or premium if certifying as tobacco or e-cigarette user) will be the first of the month after PEBA receives the form.
- If a change in status occurs that changes a subscriber's status for tobacco-use (i.e., a subscriber who does not smoke marries and enrolls his new spouse who does smoke), the subscriber must indicate the appropriate Tobacco Coverage on the paperless enrollment or complete a new Certification form and submit to PEBA with the NOE. The effective date for the premium will be the effective date of the coverage change on enrollment.

Subscribers may apply to remove the premium once they and their covered spouse and/or child(ren) are tobacco- and e-cigarette-free for six months or if all covered individuals who use tobacco and e-cigarettes completed the Quit For Life smoking cessation program. They may certify by completing the Certification form and submitting it to the benefits administrator (or to PEBA if a retired, COBRA or survivor subscriber of a state agency, higher education institution or public school district). The premium will be removed the first of the month after PEBA receives the form.

Certification forms should not be held. They should be sent to PEBA immediately after being signed and dated.

MoneyPlus enrollment

MoneyPlus is offered to all full-time employees who are also eligible for health, dental and vision coverage, regardless of whether they are enrolled in coverage. This program, administered by ASIFlex, was designed in compliance with sections 105, 125, 129 and 223 of the Internal Revenue Code (IRC).

MoneyPlus offers five features: the Pretax Group Insurance Premium feature, the Medical Spending Account (MSA), the Dependent Care Spending Account (DCSA), the Health Savings Account (HSA), and the Limited-use MSA. Participants in MSA, DCSA and LMSA accounts must re-enroll each year during October enrollment. Refer to the IBG for eligibility rules and information regarding these features.

Note: In 2020, the Dependent Care Spending Account (DCSA) is capped at \$1,750 for highly compensated employees. However, the \$1,750 cap is subject to adjustment in mid-year if PEBA's DCSA does not meet the *Average Benefit Test*. The test is designed to make sure highly compensated employees don't receive a benefit that is out of proportion to the benefit received by other employees. For 2020, the Internal Revenue Code defines a highly compensated employee as someone who earned \$127,000 or more in calendar year 2019.

Effect of MoneyPlus on other retirement plans

State retirement plan

Contributions to or benefits from the retirement systems administered by PEBA are based on employee's gross salary. Participation in MoneyPlus has no effect on pension contributions or benefits.

Deferred Compensation

Contributions to a Deferred Compensation account are based on an employee's net salary. Pretax dollars set aside for MoneyPlus elections are not included in income when determining the maximum

that can be contributed to a Deferred Compensation account.

Social Security

Pretax dollars set aside for MoneyPlus elections are not subject to Social Security taxes. Therefore, there may be a slight reduction in future Social Security benefits.

Employees do not typically contribute to a DCSA for more than a few years, but employees may contribute to an MSA or HSA for many years, and the amounts contributed may vary significantly, year to year.

Employees should consult their tax preparer/advisor to discuss their options.

If both spouses are eligible

- If both spouses are eligible employees, each may participate in MoneyPlus.
- Either spouse may claim an expense, but not both.

Effective dates for enrollment and changes

The effective dates for enrollment and changes in the Medical Spending Account (MSA) and Dependent Care Spending Account (DCSA) are the same as for health, dental and vision coverage for new hires; change in status effective dates will vary. Eligible employees have 31 days to enroll or to make changes due to a change in status.

Eligible employees may enroll in a MoneyPlus Health Savings Account (HSA) at any time. They may change their HSA elections on a monthly basis. HSA changes become effective the first of the month following the change.

Review MoneyPlus features

Pretax Group Insurance Premium

This feature allows employees to pay insurance premiums for health, dental, vision and up to \$50,000 of Optional Life coverage before taxes. Once enrolled, the employee does not need to re-enroll each year.

Be sure to forward the election to your payroll office.

An employee does not have to participate in the Pretax Premium feature to participate in the spending accounts.

Medical Spending Account and Dependent Care Spending Account

Employees can take advantage of tax-favored accounts to save money on eligible medical and dependent care costs.

Provide a copy of the [MoneyPlus flyers](#) and refer the employee to www.ASIFlex.com/SCMoneyPlus. Note the monthly administrative fees.

- To participate in either account, the employee must enroll and elect an **annual** contribution amount.
- He must re-enroll each October to continue participating the following year.
- The ASIFlex debit card is provided to MSA participants at no charge.
- Refer to the MoneyPlus COBRA section for employees who are retiring or otherwise terminating employment.

Limited-use Medical Spending Accounts are available to employees enrolled in the Savings Plan and a Health Savings Account. A Limited-use MSA will pay for expenses the Savings Plan does not cover, like dental and vision care.

Comptroller General agencies only

If your payroll is processed through the CG's office, complete a P-4 payroll change form and return it to the benefits office for all changes to existing deductions or additions of new deductions.

Medical Spending Account and Dependent Care Spending Account rules

Refer to the IBG for the eligibility information regarding these accounts.

- Participants may not be reimbursed twice for the same expense; an expense is not

reimbursable if it is already covered under insurance or has been claimed through a spouse's flexible spending account.

- An employee has until December 31 to spend funds deposited in his MSA or Limited-use MSA during that year. An employee can carry over up to \$500 of unused funds into the next plan year.
- An employee has until March 15 to spend any remaining funds deposited in his DCSA from January through December of the previous year.
- An employee has a 90-day *run-out period* (until March 31) to file claims for services incurred during the plan year.
 - An employee will forfeit any unused funds in his MSA or Limited-use MSA over the \$500 carryover amount not claimed by March 31.
 - An employee will forfeit any unused funds in his DCSA not claimed by March 31. These funds cannot be returned to the employee or carried forward to a new plan year.
- ASIFlex provides easy access to account statements online or via the mobile app. In addition, account information is provided with each reimbursement.
- PEBA, at its discretion, may elect to send statements to participants who have an available balance. The statements are sent based on participant preference of email/text alert or USPS mail, and not more frequently than quarterly.
 - ASIFlex includes a reminder of the 90-day run-out period in the statements.

Medical Spending Accounts only

- Generally, the expense must be incurred prior to reimbursement. Incurred means that the service or supply has been provided that gives rise to the expense, regardless when paid or billed.

- If the employee has an ASIFlex debit card, ASI will auto-adjudicate debit card transactions it can match to claims received from other vendors. If ASIFlex cannot validate a claim, the employee will need to provide documentation for that transaction. The account must be reimbursed for any ineligible expenses that were paid with the card.
- Requests for documentation are emailed and posted online to the employee's ASIFlex account. The employee will have 47 days to respond or the card will be deactivated. The employee will receive three notices before the card is deactivated.
- When documentation is submitted, the employee's card will be automatically reinstated.
- If the employee does not have or use the ASIFlex debit card, he will need to submit a claim online or via the ASIFlex mobile app. The employee may also submit a paper claim form, along with any pertinent documentation.
- Any debit card transactions not cleared by March 31 after the plan year ends are in violation of IRS guidelines and may be taxable as income. In this situation, the transactions will be reclassified by the employer and may need to be included on next year's W-2 as income.
- Orthodontia — There are special rules regarding orthodontia:
 - The initial service (banding) must have occurred before reimbursements may begin.
 - A contract payment agreement from your orthodontist can be provided with your claim and you can be reimbursed as payments are made based on the agreement. You must also provide proof of payment and reimbursement is made from the plan year in which the payment is made.

Whose expenses are eligible under an MSA?

- Employee;
- Employee's spouse;

- Employee's qualifying child; or
- Employee's qualifying relative.

An individual is a **qualifying child** if he is not someone else's qualifying child, and:

- Is a U.S. citizen, national or resident of the U.S., Mexico or Canada;
- Has a specified family-type relationship to the employee: son/daughter, stepson/stepdaughter, eligible foster child, legally adopted child, or child placed for legal adoption;
- Lives in the employee's household for more than half of the tax year;
- Does not reach age 27 during the taxable year; and
- Has not provided more than half of his own support during the tax year.

An individual is a **qualifying relative**, if he is a U.S. citizen, national or resident of the U.S., Mexico or Canada, and:

- Has a specified family-type relationship to the employee, is not someone else's qualifying child and receives more than half of his support from the employee during the tax year, or
- If no specified family-type relationship to the employee exists, is a member of, and lives in, the employee's household (without violating local law) for the entire tax year and receives more than half of his support from the employee during the tax year.
- "Qualifying relative" is a federal term and has no bearing on whether you can cover that person as a dependent under the state insurance benefits.

Note: There is no age requirement for a qualifying child if he is physically and/or mentally incapable of self-care. An eligible child of divorced parents is treated as a child of both, so either or both parents can have an MSA.

Dependent Care Spending Accounts only

- Sufficient funds must be available for eligible expenses to be reimbursed.
- Funds are posted to participants' accounts upon processing of MoneyPlus payrolls.
- Claims for which there are insufficient funds will be held and processed as the funds become available; the employee should not need to refile.
- The expense (or period of service, such as a month's worth of daycare) must be incurred prior to reimbursement.

Whose expenses are eligible under a DCSA?

The employee may use his DCSA to receive reimbursement for eligible dependent care expenses for qualifying individuals. A qualifying individual includes a **qualifying child** if the child:

- Is under age 13 or is physically or mentally incapable of self-care;
- Is not someone else's qualifying child;
- Is a U.S. citizen, national or resident of the U.S., Mexico or Canada;
- Has a specified family-type relationship to the employee; and
- Spends at least eight hours per day in the employee's home.

A qualifying individual includes the employee's **spouse** if the spouse:

- Is physically and/or mentally incapable of self-care;
- Lives in the employee's household for more than half of the tax year; and
- Spends at least eight hours per day in the employee's home.

A qualifying individual includes the employee's **qualifying relative** if the relative:

- Is a U.S. citizen, national or resident of the U.S., Mexico or Canada;
- Is physically and/or mentally incapable of self-care;

- Is not someone else's qualifying child;
- Lives in the employee's household for more than half of the tax year;
- Spends at least eight hours per day in the employee's home; and
- Receives more than half of his support from the employee during the tax year.

Note: If the employee is the tax dependent of another person, he cannot claim DCSA expenses for other qualified individuals. The employee cannot claim a qualifying individual if that individual files a joint tax return with a spouse. If the parents of a child are divorced or legally separated, only the custodial parent can be reimbursed for child care through the DCSA.

Health Savings Account

The Savings Plan goes hand in hand with a Health Savings Account, or HSA, which pays for future out-of-pocket medical expenses.

Provide a copy of the [Health Savings Account flyer](#). Note the monthly administrative fees and Central Bank fees.

To participate, the employee must enroll in the Savings Plan. Opening an HSA bank account online with Central Bank that will receive those contributions is also required.

1. Go to www.peba.sc.gov/moneyplus.html and select Open HSA Bank Account with Central Bank.

Central Bank charges HSA participants a monthly maintenance fee of \$1.25 for balances less than \$2,500, and it will be automatically deducted from the account.

Comptroller General agencies only

If your payroll is processed through the CG's office, complete a P-4 payroll change form and return it to the benefits office for all changes to existing deductions or additions of new deductions.

Health Savings Account rules

- If both spouses contribute to an HSA, and one of them has family coverage (employee/spouse, employee/children or full family coverage), their combined HSA contributions cannot exceed the IRS-allowed limit for family coverage. If both spouses have single coverage (employee-only coverage), each may contribute up to the IRS-allowed limit for single coverage.
- Expenses are reimbursable only if there are sufficient funds in the account. Participants may use their HSA debit cards (Central Bank) to get funds directly out of their accounts for eligible expenses; they do *not* request reimbursement through ASIFlex.
- Participants may not be reimbursed twice for the same expense; an expense is not reimbursable if it is already covered under insurance. Participants are solely responsible for maintaining proper documentation and providing it to the IRS if requested.
- Central Bank provides monthly statements online to participants.
- By IRS regulations, amounts not claimed after the year's end may be carried forward to subsequent tax years.
 - An employee may defer reimbursements, until later tax years, so long as the eligible expenses were incurred after the HSA was established and the employee is keeping sufficient records to document the eligible expenses.
 - Participants will receive tax reports from Central Bank to use for tax filing purposes.

GEA TRICARE Supplement Plan enrollment

When enrolling an employee in the GEA TRICARE Supplement Plan, submit a copy of the employee's TRICARE Card with the enrollment.

- PEBA will process the enrollment and send information to Selman & Company.
- Selman & Company will verify the employee's eligibility with the Defense Enrollment Eligibility Reporting System (DEERS).
 - If the employee is eligible, Selman & Company will send him a GEA TRICARE Supplement Plan enrollment packet.

Assisting a newly eligible variable-hour, part-time or seasonal employee

New variable-hour, part-time or seasonal employees are not offered benefits when they are first hired. Instead, the employer must measure the employee's hours over an initial 12-month measurement period to determine whether the employee will be eligible for benefits.

A new variable-hour, part-time or seasonal employee credited with an average of 30 hours per week during his Initial Measurement Period may enroll during an Initial Administrative Period, which begins the day after the end of his Initial Measurement Period and ends the last day of the same calendar month. Once an employer deems an employee eligible for benefits, the employee remains eligible for 12 months during his Initial Stability Period regardless of the number of hours the employee works.

Example: An employee hired on December 5, 2020, would not have been employed for the entire Standard Measurement Period (October 4, 2020-

October 3, 2021); therefore, the employee will have his own Initial Measurement Period, Administrative Period and Stability Period:

- Initial Measurement Period: January 1, 2021-December 31, 2021
- Initial Administrative Period: January 1, 2022-January 31, 2022
- Initial Stability Period: February 1, 2022-January 31, 2023

During the Administrative Period, the employer would review the hours worked by the employee during his Initial Measurement Period. If the employee is deemed eligible for benefits, the employer would offer coverage and complete the enrollment by January 31, 2022. If the employee was deemed eligible for benefits, he would remain eligible for the duration of his Stability Period regardless of the number of hours he works.

In accordance with the ACA and as defined in paragraphs 3.23 of the *Plan of Benefits* document, variable-hour, part-time and seasonal employees who are eligible for benefits are eligible for all benefits.

Eligible employees must elect or refuse coverage within the employee's designated Administrative Period. Coverage is effective the first of the month after the end of the Administrative Period. Employees enrolling in a health plan must also certify their tobacco use.

The employee is allowed to change his mind about an original selection within the Administrative Period. To make a new selection, a paper *Notice of Election* must be signed within the 31-day window and submitted to PEBA for processing as a revision.

Completing the enrollment

The same procedures apply for completing the enrollment of an active subscriber (see Pages 16-19) with the following exception:

STATUS: Employer should select the category for the type of employee who is enrolling in coverage.

- While variable-hour, part-time and seasonal employees are eligible for active employee benefits, they are not automatically eligible for retiree coverage if they retire from a nonpermanent position. See the Retiree section beginning on Page 87 for retiree eligibility requirements, including that the last five years of active employment must be full-time, permanent and consecutive.

Assisting a permanent, part-time teacher

As defined in S.C. Code Ann. §59-25-45 and in paragraph 2.53 of the Plan of Benefits document, permanent, part-time teachers of S.C. public schools, the S.C. Department of Corrections, the S.C. Department of Juvenile Justice and the S.C. School for the Deaf and Blind may be eligible for:

- Health (State Health Plan and GEA TRICARE Supplement Plan).
- Dental Plus and Basic Dental.
- State Vision Plan.
- MoneyPlus.

Permanent, part-time teachers are **not** eligible for:

- Basic Life insurance.
- Optional Life insurance.
- Dependent Life insurance for children or spouses.
- Basic Long Term Disability.
- Supplemental Long Term Disability.

The employee must be in a contract position and receive an EIA (Education Improvement Act of 1984) salary supplement. In addition to classroom teachers, this may also include other academic personnel, such as librarian/media specialists, guidance counselors, ROTC (Reserve Officer Training Corps) instructors, school nurses, social workers, psychologists, audiologists or other instructional staff. Contact the Department of Education at 803.734.8122 for additional information pertaining

to the specific law or determining eligibility of a position.

The employee must work at least 15 hours per week, but fewer than 30 hours per week.

- There are three part-time categories based on the number of hours worked per week (Category I = 15-19 hours; Category II = 20-24 hours; Category III = 25-29 hours). Premiums are based on the applicable category.

An employee who is eligible as a permanent, part-time teacher and also eligible as a spouse under a covered spouse's file, may elect coverage as a permanent, part-time teacher or as spouse, but not both. A permanent, part-time teacher with health, dental and/or vision coverage as a subscriber cannot be covered on the spouse's plan under any benefit (health, dental, vision or Dependent Life).

- If the employee wants to remain on his spouse's coverage, complete an [Active Part-time Teachers NOE](#) refusing all coverage and send it to PEBA.

While permanent, part-time teachers are eligible for active employee benefits under § 59-25-45, they are not automatically eligible for retiree coverage if they retire from a part-time teacher position. See the Retiree section beginning on Page 87 for retiree eligibility requirements, including that the last five years of active employment must be full-time and continuous.

Eligible employees must enroll within 31 days of date of hire by enrolling through EBS/MyBenefits or by completing an [Active Part-time Teachers NOE](#).

Effective dates of coverage are the same as for other new hires. The 31-day window for elections and changing elections is also the same as for other new hires.

Employees enrolling in a health plan must also certify their tobacco use.

Completing the enrollment

When completing the permanent Part-Time Notice of Election, select one category based on the number of hours worked each week. The benefits administrator should confirm the accuracy of the selection.

Process for medical emergencies

If a subscriber has a medical emergency and an enrollment or change needs to be processed the same day, complete the transaction in EBS. A BIN will be generated immediately. See Section B, Using the Online Enrollment System, for more information.

- After the transaction is complete and you have the documentation, if any, call PEBA's BA Contact Center. You will be given a number to use to fax the documentation to PEBA. If you are unable to get the employee's signature on the SOC or SOE, include a copy of the signed Notice of Election form.
- If the subscriber's file is in suspense because of a rejection, call PEBA's BA Contact Center. The call center representative will delete the suspended transaction so that you can complete the transaction in EBS. After the fax is received, the call center representative will release it and update the third-party claims processors.

A subscriber can obtain medical services before he has an insurance card by giving his member ID to his provider.

- If the subscriber is enrolled, his member ID is ZCS followed by his BIN.
- If the subscriber is enrolled in the GEA TRICARE Supplement Plan, his member ID is PC followed by his BIN.

A subscriber can obtain prescription drugs before he has an insurance card.

- State Health Plan subscribers can tell the pharmacist they are with Express Scripts. The pharmacist may only need the member's name and his eight-digit claim. If the pharmacist needs more information from the card:
 - **All active employees and their covered dependents** should provide:
 - RxGroup: SCPEBAX;
 - RxPCN: A4; and
 - RxBIN: 003858.
 - **Retirees not enrolled in Medicare** should provide:
 - RxGroup: SCPEBAX;
 - RxPCN: A4; and
 - RxBIN: 003858.
 - **Retirees enrolled in Medicare** should provide:
 - RxGroup: 7258MDRX;
 - RxPCN: MEDDPRIME; and
 - RXBIN 610014.

National Medical Support Notices

National Medical Support Notices (NMSNs) are forms sent to employers when an employee is under an existing court or administrative order to provide insurance for his child(ren). Timely completion helps ensure children have the required coverage.

If you receive an NMSN, email it to PEBA at medicalsupportnotices@peba.sc.gov as soon as possible. The format of the notice may vary, but it will always say National Medical Support Notice at the top of the first page, and it will have sections labeled Employer Response and Plan Administrator Response.

- Complete **only** the Employer Response section and return it to the issuing child

support agency before you send a copy to PEBA.

- You do not have to complete an NOE.
- Please note: The information on the custodial parent and child(ren) contained on the NMSN should not be shared with the employee. If the employee has questions concerning the coverage requirements and plan choice, please refer the employee to the issuing agency.
- PEBA will complete the Plan Administrator Response and send it to the issuing agency. PEBA will also complete any extra forms or questionnaires about health insurance that might be included. You will be notified if election changes are made.

NOTE: Special eligibility situation rules do not apply to NMSNs. Subscribers may not make changes to their benefits other than those specified in the NMSN, which PEBA will determine. Subscribers are not allowed to make coverage changes through MyBenefits.

Compliance with the NMSN is mandatory under federal law. PEBA **cannot** discontinue coverage until the issuing agency sends an updated NMSN or other order.

Rules and procedures for late entrants

Health plans

- The employee must wait until the next October enrollment period to enroll as a late entrant or to add a spouse or child(ren) as a late entrant. Someone who enrolls due to a special eligibility situation is not considered a late entrant.
- No medical evidence of good health is required for subscribers, their spouses or children.
- There are no pre-existing condition exclusions under any of the health plans offered through PEBA.

Dental

- The employee must wait until the next open enrollment period of an odd-numbered year to enroll as a late entrant or to add a spouse or child(ren) as a late entrant.
- There is no dental underwriting for subscribers, their spouses or children.
- There are no pre-existing condition exclusions under Dental Plus or Basic Dental.

Vision care

(Group number 9925991)

- The employee must wait until the next October enrollment period or special eligibility situation to enroll in the State Vision Plan as a late entrant or to add a spouse or child(ren) as a late entrant.
- There is no medical evidence of good health for subscribers, their spouses or children.
- There are no pre-existing condition exclusions under the State Vision Plan.

Life insurance

Optional Life

(Policy number 200879)

- If they do not participate in the MoneyPlus pretax premium feature, eligible participants may enroll in Optional Life or increase coverage throughout the year.
 - Late entrants must provide evidence of insurability and be approved.
- If they do participate in the MoneyPlus pretax premium feature, eligible participants may enroll in Optional Life or increase coverage only during announced enrollment periods or within 31 days of a special eligibility situation.
 - Late entrants must provide evidence of insurability and be approved.

Refer to Page 51 for the procedures for adding and changing Optional Life insurance coverage outside of a new hire situation.

Dependent Life-Spouse

(Policy number 200879)

- Eligible spouses may be added throughout the year.
- Evidence of insurability is required for spouses enrolled as late entrants.

Refer to Page 53 for the procedures for adding and increasing Dependent Life insurance coverage with evidence of insurability.

Dependent Life-Child

(Policy number 200879)

- Eligible dependent children may be added throughout the year.
- No evidence of insurability is required for children enrolled as late entrants.

Supplemental long term disability

(Policy number 621144A)

- Have the employee complete the [*Medical History Statement Long Term Disability*](#).
- Send the completed original to Standard Insurance Company.
- When an approval is received from The Standard, have the employee complete a paper *Notice of Election* to select the coverage for which he was approved. This may be done earlier and held for approval from The Standard.
- Send the approval from The Standard with the paper NOE to PEBA.
- Premiums start with the effective date of coverage (first of the month after approval).

Changes in status and special eligibility situations

(Health, Dental Plus/Basic Dental, State Vision Plan, Dependent Life, MoneyPlus)

Enrollment changes must be requested within 31 days of the changes in status that follow, and any supporting documentation must be submitted. Changes not made within 31 days of the event cannot be made until the next open enrollment period or until another change in status or special eligibility situation occurs.

If the change in status or special eligibility situation changes the tobacco-use status, the subscriber must indicate the appropriate Tobacco Coverage on the paperless enrollment or complete a new Certification form and submit to PEBA with the NOE. The effective date for the premium will be the effective date of the coverage change on enrollment.

More information on changes related to a spouse or child(ren) can be found on Page 105.

Gain of other group coverage

Effective date to drop PEBA coverage: first of the month after gaining other coverage or the first of the month if coverage is gained on the first of the month. See exceptions for gaining Medicare and Medicaid effective dates below.

An exception to the 31-day rule exists when a spouse who gains coverage or becomes eligible for coverage *as a subscriber of a participating employer* must be dropped from the employee's coverage. If the employee fails to drop the ineligible spouse within 31 days, the spouse may be dropped retroactively to coincide with the date the spouse was added to coverage at the other participating employer.

An employee may terminate health, dental and/or vision coverage if he gains other group coverage. He can drop only the type of coverage he gained.

An employee may drop a spouse or child(ren) from coverage if his spouse or child(ren) gains other group coverage. Only the spouse or children who gained other coverage may be dropped. The spouse or child(ren) can be dropped only from the type of coverage he gained.

- However, if the spouse is gaining coverage as an employee of a *participating employer*, the subscriber must drop the spouse within 31 days; he cannot wait until the open enrollment period.
- If a spouse or child(ren) gains eligibility for coverage and attempts to enroll as an employee of a *participating employer*, PEBA will reject the enrollment, because the spouse or child(ren) must be terminated from the other coverage first.

A gain of other group coverage notice is required only if the group is **not** participating with PEBA insurance benefits. The notice must be submitted in EBS or attached to the NOE.

- The gain of coverage notice must include the effective date of coverage, the type(s) of coverage (health, dental and/or vision) and list all individuals who gained coverage.
- The notice must state gained health coverage to change coverage level or drop health coverage; it must state gained dental coverage to drop dental coverage; it must state gained vision coverage to drop vision coverage. *Exception:* Medicaid includes health, dental and limited vision coverage (for children only) automatically.

If the group is participating with PEBA insurance benefits, write *Gained State Coverage* at the top of the NOE.

If the subscriber has not received the gain of coverage notice, and the deadline to enroll in PEBA coverage is nearing, complete and submit the NOE without the letter. Submit the letter as soon as it is available. Changes will not be processed until all documents have been received.

Gain of Medicare coverage

Effective date to drop PEBA coverage: first of the month after the gain of Medicare or the first of the month if Medicare is gained on the first of the month. If the effective dates of Part A and Part B are different, the subscriber can make a change in coverage through PEBA only within 31 days of the confirmation letter from the Social Security Administration. The letter is typically sent when the subscriber becomes eligible for Part A.

An employee may terminate health coverage if he gains Medicare.

An employee may drop a spouse or child from health coverage if his spouse or child gains Medicare. Only the spouse or children who gained Medicare may be dropped.

A copy of the Medicare card, verifying gain of Medicare coverage, must be attached to the NOE.

Note on Medicare Part B and Medicare Part D: Most **active** employees who become eligible for Medicare at age 65 should delay enrolling in Medicare Part B, because their coverage through PEBA remains primary while they are working. Likewise, most active employees should not sign up for a separate Medicare Part D plan, because their prescription drug expenses will continue to be covered through their plan with PEBA. If an employee signs up for Part D, PEBA will *not* be able to drop his prescription drug coverage.

There are exceptions for employees who become eligible for Medicare due to disability or end-stage renal disease. Refer to the [Insurance Benefits Guide](#) or call PEBA's Customer Contact Center for more information.

- *When an individual begins dialysis for end-stage renal disease*, he becomes eligible for Medicare typically three months after beginning dialysis. At this point, he begins a coordination period of 30 months. During this time, his coverage through the State Health Plan remains primary. When the coordination period ends, Medicare

becomes primary. The coordination period applies whether the subscriber is an active employee, a retiree, a survivor or a covered spouse or child, and regardless of whether the subscriber was already eligible for Medicare due to another reason, such as age. If the subscriber was covered by the Medicare Supplemental Plan, he will be changed to the Standard Plan during the 30-month coordination period.

Gain of Medicaid coverage

Effective date to drop PEBA coverage: effective date of the Medicaid coverage.

Exceptions to the 31-day rule: If the subscriber and his covered family members become eligible for Medicaid or the Children's Health Insurance Program (CHIP), the subscriber has 60 days from the date of notification to drop coverage through PEBA. If the Medicaid effective date is retroactive more than 60 days before the date of notification, then the effective date will be the first of the month after the request. If the subscriber notifies PEBA more than 60 days after he was notified by Medicaid, no changes are allowed.

An employee may terminate health, dental and/or vision coverage if he gains Medicaid.

An employee may drop a spouse or child(ren) from coverage if his spouse or child(ren) gains Medicaid. Only the spouse or children who gained Medicaid may be dropped.

A copy of the Medicaid approval letter must be attached to the NOE or submitted in EBS.

Medicaid coverage includes health, dental and vision coverage. The vision coverage includes an annual eye exam and a pair of glasses following cataract surgery. Vision coverage for children younger than age 21 includes one eye exam and one pair of glasses once a year. For most adults 21 and older, this dental coverage includes emergency services only, such as extractions or treatment for acute infections. Dental coverage for children younger than age 21 includes basic coverage with

preventive services. For more information on Medicaid coverage, contact DHHS (contact information will be on the Medicaid approval letter).

Loss of other group coverage

(Includes Medicare and Medicaid)

Effective date: the date of the loss of coverage.

Exceptions to the 31-day rule: If the subscriber and his covered family members lost coverage through Medicaid or the Children's Health Insurance Program (CHIP), the subscriber has 60 days to enroll in coverage through PEBA.

If the subscriber loses other health coverage, and he is not already enrolled in health through PEBA, he can enroll himself, his spouse and his children in health, Dental Plus or Basic Dental and vision. The subscriber must enroll in coverage he is adding for his spouse or children. He cannot drop or change his current coverage.

- If the subscriber is already enrolled in health through PEBA, he cannot make changes.

If the subscriber loses other dental coverage, he can enroll in Dental Plus or Basic Dental.

If the subscriber loses other vision coverage, he can enroll in vision.

If the subscriber's spouse or child(ren) loses other health coverage, he can enroll himself and the spouse or child(ren) who lost coverage in health, Dental Plus or Basic Dental and vision. The subscriber must enroll in coverage he is adding for his spouse or children. If the subscriber is already enrolled in health, he may change plans if he adds the spouse or child who lost coverage. He cannot drop his current coverage.

If the subscriber's spouse or child(ren) loses other dental coverage, he can enroll himself and the spouse or child(ren) who lost coverage in Dental Plus or Basic Dental. The subscriber must enroll in coverage he is adding for his spouse or children.

If the subscriber's spouse or child(ren) loses other vision coverage, he can enroll himself and the spouse or child(ren) who lost coverage in vision. The subscriber must enroll in coverage he is adding for his spouse or children.

If the subscriber's spouse loses other life insurance coverage, it is not a special eligibility situation. However, the subscriber may add the spouse to Dependent Life with evidence of insurability throughout the year. If the subscriber's spouse loses life insurance coverage as an employee of a PEBA insurance benefits-participating employer, the spouse may be added to Dependent Life (\$10,000 or \$20,000 in coverage) without evidence of insurability.

Documentation of dependent eligibility should be attached to the NOE or submitted in EBS.

- A marriage license or Page 1 of the employee's most recent federal tax return is required to add a spouse.
- A birth certificate (long form) showing the subscriber as the parent is required to add a child.
- A marriage certificate is required to add a stepchild. Return the completed form to PEBA.

Documentation of loss of coverage should be attached to the NOE. Acceptable documentation is a creditable coverage letter or a notice that includes the effective date of the loss of coverage, the type of coverage lost (health, dental and/or vision), and the names of all individuals who lost coverage.

- If the coverage that was lost was through a *participating employer*, write *Lost State Coverage* at the top of the NOE. This will alert PEBA staff to access the previous coverage data on the individual.
- If the subscriber loses other health coverage, and he is not already enrolled in health through PEBA, his spouse and children can be added to health, Dental Plus, Basic Dental and vision even if they are

not listed on the loss of coverage letter. The letter does not need to state subscriber lost dental or vision for him to enroll in those coverages.

- If the subscriber's spouse or child(ren) loses other health coverage, the loss of coverage letter does not need to say spouse or child(ren) lost dental or vision for the spouse or child(ren) to enroll in Dental Plus or Basic Dental and vision.

If the subscriber has not received the loss of coverage letter, and the deadline to enroll in PEBA coverage is nearing, complete and submit the NOE without the letter. Submit the letter as soon as it is available. Changes will not be processed until all documents have been received. The effective date will remain the date of loss of other coverage.

Note about premiums: If the employee is enrolled in the MoneyPlus Pretax Group Insurance Premium feature, premiums must be paid post-tax for retroactive coverage back to the date of loss of coverage. Premiums may be paid pretax beginning the first of the month following the date of the request.

Loss of TRICARE coverage

Effective date to drop PEBA coverage: first of the month after a subscriber or dependent is no longer eligible for TRICARE, if enrolled in the TRICARE Supplement.

Selman & Company provides employers with monthly eligibility reports. If a subscriber or dependent is no longer eligible for TRICARE, submit a paper NOE and a copy of the report from Selman & Company to PEBA to cancel coverage.

- Strike through any information that doesn't apply to that specific subscriber or dependent.
- If the report lists more than one subscriber or dependent who lost eligibility, attach a copy of the report to each NOE.

MoneyPlus change in status rules

The rules and effective dates for changes in status are similar to those for health insurance. There are some additional changes that are allowed by the IRS. Refer to the [Flexible Benefits Plan](#) document for these allowed changes. For example, a child turning age 13, who is no longer eligible for dependent care, is an allowed change in status event.

Eligible employees have 31 days to enroll or to make a change when a qualifying change in status occurs. The payroll adjustment must coincide with the effective date of the change in status.

Changes/new elections must be consistent with a qualifying family status change. For example, decreasing your Medical Spending Account contributions when your adult child gets a job and coverage elsewhere is consistent with the gain of other coverage; increasing your contributions is not.

- **Pretax Group Insurance Premium feature:** if the employee is eligible to change health, dental, vision or Optional Life coverage due to a change in status, he may also enroll in or drop his Pretax Group Insurance Premium feature.
- **Dependent Care Spending Account:** if a DCSA is terminated, the employee can continue to submit claims, while employed, until the end of the year or until the account is exhausted.
- **Medical Spending Account:** if an MSA is terminated, the employee can submit expenses incurred only through the date of termination.
- **Health Savings Account:** Change in status rules do not apply to HSAs. HSA contributions may be started at any time and stopped or changed monthly, regardless of the situation.

Refer to the Transfers and Terminations section and the COBRA section of this manual for more

information on continuation of MSA and HSA accounts at termination.

Completing the enrollment for a change in status

Use EBS when an employee wants to change his MoneyPlus account(s) due to a change in status.

Select MoneyPlus as the Reason for Change and select the Sub-Reason from the drop-down list. Enter the date of the event, not the effective date of the change. Complete the enrollment change(s) and apply to MyBenefits or Current EBS.

Note that certain changes are not allowed due to the defined change reason.

Deductions for any accounts which the employee has but does not wish to change as a result of the change in status, will remain the same.

PEBA does not require supporting documentation, nor does ASIFlex make decisions as to the employee's eligibility. It is the benefit administrator's responsibility to verify change in status eligibility.

If completing the enrollment change(s) on a paper *Notice of Election* form, follow the NOE instructions and check and date all qualified change events for MSA and DCSA accounts, then return the completed form to PEBA.

If PEBA does not receive the enrollment change before the participant submits claims related to the change in status, those claims may be rejected. If ASIFlex does not receive adjusted payroll data that matches the payroll effective date or payroll amount on the form, related claims may be rejected.

Coverage changes for permanent, part-time teachers

(Health, dental and vision)

The policies and procedures regarding health, dental and vision changes for active subscribers apply also to permanent, part-time teachers.

Increase or decrease in the number of contract hours

If the increase or decrease in an employee's contracted work hours causes a change in status (i.e., from 15 to 25 hours per week, etc.):

- Submit a new NOE, reflecting the change in status.
- If this is a temporary change, you do not have to notify PEBA, and no changes should be made.
- If an increase in hours makes the employee eligible as a permanent, part-time teacher:
 - The date of hire will be the date of the contract change.
 - The effective date will be the first of the month after the date of the contract change (or the first working day of the month, if applicable).

If an employee's work hours are contractually reduced to fewer than 15 hours per week:

- Complete the termination in EBS, or submit an [Active Termination](#) form to PEBA. Change is effective the first of the month after the work hours are reduced.

The employee may make new health and dental selections based on an increase or decrease in hours.

- If the decrease in hours places the employee in a lower category (e.g., he enrolled in Category III working 26 hours

and the contract changes to 23 hours), he may decrease or increase his coverage.

- If the increase in hours places the employee in a higher category (e.g., he enrolled in Category I working 17 hours and the contract changes to 23 hours), he may select and/or increase his benefits.
- If the increase in hours reaches 30 hours per week, classifying him as a permanent, full-time employee, he is eligible to make all new selections. Treat him as a new hire and offer all benefits to him, effective the first of the month after he reaches permanent, full-time status.

Other coverage changes

Optional Life

To determine the allowable timeline for changes to Optional Life coverage, review whether the employee participates in the MoneyPlus Pretax Group Insurance Premium feature.

Not participating in MoneyPlus

The 31-day rule does not apply if a subscriber is **not** participating in the MoneyPlus Pretax Premium feature. Subscribers **not** participating in the Pretax Premium feature may:

- Add or increase coverage at any time during the year by providing medical evidence, with approval from MetLife:
 - Complete a *Statement of Health* form and submit it to MetLife for review. If additional information or medical data is needed, MetLife will send a letter to the subscriber.
 - MetLife allows 60 days to respond. A reminder letter is sent if no response is received within 31 days. If no response is received in another 31 days, the file is closed.
 - MetLife subcontracts for a paramedical exam, if an exam is necessary to make a determination.

If required, this step also follows the same 31- and 60-day process.

Once MetLife receives all needed information, a decision will be made within 10 business days. MetLife mails a Notification Statement to the subscriber and emails the benefits administrator.

Submit the change in EBS by selecting Optional Life Changes – Not a MoneyPlus participant as the Reason for Change and select the Sub-Reason from the drop-down list. Enter the approval date from MetLife. Complete the enrollment change(s) and apply to MyBenefits or Current EBS. A copy of the MetLife approval is required as supporting documentation.

If submitting on a *Notice of Election* form, forward a copy of the weekly Statement of Health Report from MetLife and the NOE that shows the increase in coverage to PEBA so the subscriber's file can be updated and the billing statement adjusted.

The effective date will be the first of the month after approval from MetLife.

- Add or increase coverage, without medical evidence, due to a special eligibility situation:
 - The change must be made within 31 days of the special eligibility situation (marriage, birth, adoption or placement for adoption).
 - The effective date of the change will be the first of the month after the change is requested.
 - If the subscriber refused Optional Life as a new hire, he may add coverage, up to \$50,000 (in increments of \$10,000). If the subscriber is already enrolled in Optional Life, he may increase coverage, up to an additional \$50,000 (in increments of \$10,000

and not to exceed the maximum amount allowed).

- Decrease coverage: effective the first of the month after the change is requested.
- Cancel coverage: effective the first of the month after the change is requested.

Participating in MoneyPlus

Changes must be made within 31 days of the special eligibility situation or the employee must wait until the next enrollment period. Subscribers participating in the Pretax Premium feature may:

- Add coverage. The Optional Life request must be consistent with the special eligibility situation. If the subscriber refused Optional Life as a new hire, he may:
 - Add coverage, up to \$50,000 (in increments of \$10,000), without medical evidence. The effective date of the change will be the first of the month after the change is requested.
 - Add coverage, more than \$50,000 (in increments of \$10,000 and not to exceed the maximum amount allowed), with medical evidence. Complete a *Statement of Health* form and submit it to MetLife for review.

Complete two NOEs. Complete the first NOE, requesting the level for which he is eligible without medical evidence (\$50,000), effective the date of the event. Complete the second NOE for the *total amount* of coverage (with medical evidence) and hold until approval is received from MetLife.

- Once approved, send the second NOE, with the weekly Statement of Health Report from MetLife, to PEBA.

- The effective date will be the first of the month after approval from MetLife.
- Increase coverage, up to an additional \$50,000, without medical evidence.
 - The effective date will be the first of the month after the change is requested.
- Increase coverage, more than \$50,000, with medical evidence.
 - Complete a *Statement of Health* form and submit it to MetLife for review. Keep a copy to hold in the pending file.

Complete two NOEs. Complete the first NOE, requesting the level for which he is eligible without medical evidence (\$50,000), effective the first of the month after the change is requested. Complete the second NOE for the *total amount* of coverage (with medical evidence) and hold until approval is received from MetLife.

- Once approved, send the second NOE, with the weekly Statement of Health Report from MetLife, to PEBA.
- Decrease coverage. The Optional Life request must be consistent with the special eligibility situation. The effective date will be the first of the month after the change is requested. *Exception:* the effective date for the death of a spouse will be the day after death, as with other benefits.
- Cancel coverage. The Optional Life request must be consistent with the special eligibility situation. The effective date will be the first of the month after the change is requested. *Exception:* the effective date for

the death of a spouse will be the day after death, as with other benefits.

Effective date note: If the employee is not *actively at work* (the employee is absent from work due to a physical or mental condition, including absence due to maternity/birth) on the date his Optional Life selection becomes effective (add Optional Life coverage or increase in the level of Optional Life), the effective date will be the first of the month after the employee returns to work for one full day. The “Actively at Work” requirement is defined in the IBG’s Life insurance chapter.

If request for additional coverage is denied

If MetLife denies additional coverage, based on evidence of insurability:

- The employee may request from MetLife, in writing, additional information regarding the denial.
- Do not forward denials to PEBA.
- If denied, the employee may reapply by submitting a new *Statement of Health* form.

Dependent Life

Dependent Life-Child

- If there is only one child on coverage, terminate the coverage in EBS.
- Other changes must be made on an NOE, dated and signed by the subscriber and the benefits administrator. *Exception:* Newborns are automatically covered for 31 days from live birth. To continue coverage, add the newborn via EBS within 31 days or submit an NOE if it’s after the 31-day window.
- Coverage may be canceled upon request, effective the first of the month after the request is made (or up to 12 months retroactively if dropping the last eligible child due to death or if the system terminates the last eligible child).
- Certification of student status or incapacitation is required for ages 19-24 to

be covered. No claims will be paid without this documentation.

- Coverage may be added throughout the year, effective the first of the month after the request.

Exception: Legal custody/guardianship is not considered a special eligibility situation for enrolling a child in Dependent Life-Child coverage or for the subscriber to enroll himself or increase his Optional Life coverage. The child must be legally adopted or placed for adoption to make these changes.

- If the request is made within 31 days of birth or the date you acquired the child, coverage will become effective the date of the event.
- The Dependent Non-confinement Provision for spouses and children, explained in the IBG and below, will apply, *except for newborns*.

Dependent Life-Spouse

- Coverage up to \$20,000 may be added within 31 days of date of marriage or within 31 days of loss of other coverage with a participating employer, without providing evidence of insurability.
- Coverage may be added, increased, decreased or canceled throughout the year.
- Evidence of insurability is required for late entry and to increase Dependent Life-Spouse coverage beyond \$20,000, up to the maximum allowed.
- Medical evidence procedures:
 - Complete an NOE, listing the spouse to be added to coverage or to have coverage increased.
 - Complete a *Statement of Health* form and submit it to MetLife for review. Keep a copy to hold in the pending file.

- Once approved, send the NOE along with the weekly Statement of Health Report from MetLife and the copy of the *Statement of Health* form to PEBA.
- MetLife will notify the subscriber of the approval/denial.
- The effective date will be the first of the month after approval from MetLife.

Effective Date note: Under the Dependent Non-confinement Provision, if a spouse or child (other than a newborn) is confined to a hospital or elsewhere due to a physical or mental condition on the date his Dependent Life selection should become effective (because Dependent Life coverage is added or there is an increase in the level of Dependent Life), the effective date will be the date the spouse or child is discharged or no longer confined. To be confined elsewhere means the spouse or child is unable to perform the normal functions of daily living or is unable to leave home without assistance.

If MetLife denies coverage, refer to the Optional Life Insurance denial information on Page 53.

Supplemental long term disability

Changes allowed throughout the year:

- Cancel coverage — effective the first of the month following the request.
- Increase the waiting period from 90 to 180 days — effective the first of the month following the request.
- Decrease the waiting period from 180 to 90 days, which requires medical evidence — effective the first of the month following approval.
- Add coverage if late entrant, which requires medical evidence — effective the first of the month following approval.

For late entrants, a [Long Term Disability](#) must also be completed and sent to Standard Insurance

Company for review. If approved, a copy of the approval will be mailed to the employee and the benefits administrator. The approval letter from The Standard must be attached to the NOE and submitted to PEBA.

MoneyPlus

Flexible spending accounts

Medical Spending and Dependent Care Spending accounts can be changed during the year only if an approved change in status event occurs and the election change is consistent with the event.

Health Savings Accounts (HSAs)

Contributions can be started at any time and stopped or changed on a monthly basis. Changes become effective the first of the month following the change.

Pretax contribution changes to HSAs must be made on a prospective basis. **Employees cannot make retroactive changes.**

To change an HSA, active employees should complete a paper *Notice of Election* form. Mark *Contribution Amount Change* and the new plan year total amount in Box 27C. To stop HSA contributions, enter \$0.

- As the benefits administrator, when you sign and date the form, you are also certifying the employee's eligibility to continue contributing to an HSA.
- Each employer's payroll center may specify when the enrollment form must be received to allow enough time to change the payroll withholding.

Employees may also contribute directly to their HSAs, through Central Bank, on an after-tax basis, according to IRS guidelines.

To close an HSA account with Central Bank:

Step 1. The employee must stop contributing to his account. He must complete and submit a *Notice of Election* form, entering \$0 in Box 27C of the form to stop the payroll deductions. Both the employee and benefits administrator must sign this form.

Completing the NOE does not close the HSA at Central Bank.

Step 2. To close the HSA with Central Bank, the employee must contact Central Bank.

Do not advise employees to leave their HSAs open with a \$0 balance. If the employee does not close his account with Central Bank, the monthly \$1.25 maintenance fee will continue, resulting in an overdraft, compounded by additional charges. If there is money remaining in the HSA, the employee may continue to use the money for qualified medical expenses. When the account balance drops below \$25, he should use the rest and contact Central Bank to close the account.

Beneficiary changes

Basic Life/Optional Life

Encourage subscribers to initiate a beneficiary designee change for Basic Life and/or Optional Life in MyBenefits.

Or use EBS when an employee wants to change a beneficiary. Select Beneficiary as the Reason for Change. Complete the change and apply to MyBenefits or Current EBS.

If using a paper *Notice of Election*, an attachment is acceptable when the number of designated beneficiaries exceeds the spaces on the NOE. Indicate on the NOE that beneficiaries are continued, or may be listed entirely, on an attachment.

- On the attachment, indicate the employee's name, SSN and the life insurance benefit with the same beneficiary information that is requested on the NOE. The attachment must be signed and dated by the subscriber and stapled to the NOE.

When multiple beneficiaries are listed, indicate percentages; otherwise, the money will be divided equally among beneficiaries. The percentages must total 100 percent and must be whole numbers — no decimals.

The effective date will be the subscriber's signature date on the requested change.

Open enrollment for active subscribers

During the October open enrollment period, eligible employees may change their coverage without having to have a special eligibility situation. Changes become effective the following January 1.

- Employees may enroll themselves, their eligible spouse and/or their eligible children in health and/or dental insurance without providing medical evidence of good health.
- Employees may cancel health coverage or drop their spouse and/or children from health coverage.
- Employees may change from one health plan to another.
- Employees may enroll in or drop State Vision Plan coverage for themselves, their eligible spouse and/or their eligible children.
- Employees may enroll or re-enroll in MoneyPlus features as follows:
 - Employees remain on the MoneyPlus Pretax Premium Feature and do not need to re-enroll.
 - Permanent full-time employees must re-enroll in the MoneyPlus Medical Spending Account and/or Dependent Care Spending Account each year.
 - Medical Spending Account participants receive the debit card at no charge. Note that a new card is not sent to the participant each year; *the card is valid for five years*.
 - Employees do not need to re-enroll in the Health Savings Account each year, if they wish to continue contributing the same amount. If they wish to change the amount they contribute, they can indicate a new amount in MyBenefits. If they wish to stop contributions or are no longer eligible to contribute, enter \$0.
- Employees enrolling in an HSA and who currently have a full (not a limited-use) Medical Spending Account can begin contributing to their HSA on January 1, if the MSA has a zero balance as of the last day of the previous plan year (December 31). MSAs are considered *other health insurance*. They will still be able to contribute the full annual amount to their HSA, as long as they remain eligible through the end of the plan year and continue to be eligible for a full 12 months after that.
- Employees participating in the MoneyPlus Pretax Premium feature may elect, make changes or cancel Optional Life. Medical evidence may be required. This does not affect the employee's eligibility to participate in an MSA or a DCSA.
- Changes to other benefits may be made as announced.

Dental coverage

- Employees may enroll in, cancel or add or drop spouse and/or children from Dental Plus or Basic Dental only during open enrollment of **odd-numbered years**.

Open enrollment procedures and helpful hints

You do not have to wait until October 1 to begin enrollment. You may begin early, if you wish.

- PEBA will make enrollment materials available as early as possible and will notify you through *PEBA Update* as they are printed and/or posted on the PEBA website. Be sure that NOEs and MyBenefits are ready before you tell your employees to start making their enrollment changes.

- Distribute *Insurance Summary* publications and federally mandated notices in October.

Encourage employees to use MyBenefits to initiate any open enrollment changes and upload supporting documentation.

After October 31, the employee's open enrollment decision is final; he does not have 31 days to change his mind.

When making coverage changes on dependents, any spouse or children to be added or deleted must be listed. Social security numbers and dates of birth are required.

If using a paper *Notice of Election*, only the requested changes need to be marked. If anything else is marked, be sure it is marked correctly to avoid unnecessary rejections or unintended changes. Check the box Enrollment under TYPE OF CHANGE in the Administrative Information section.

- If more than one NOE is submitted, PEBA will process the NOE with the latest signature date as the final, enrollment NOE.
- NOEs must be signed by October 31.
- NOEs must be signed by the benefits administrator and by the employee.
- Upload any required documentation to EBS or staple it to the NOE.
- Do not hold enrollment NOEs. Send them to PEBA as they are completed.

All open enrollment transactions must be received by PEBA by November 15; no exceptions.

If there is also a change of address, complete a universal [Name/Address Change Form](#) and submit it to PEBA immediately.

New employees or transfers hired October 2-December 31

Transfers

Employees who transfer from one participating employer to another with no break in coverage must make their enrollment elections as usual: during October, while still employed with the previous employer.

- The subscriber must advise the new employer of his October elections at the time of the transfer. The employee will need to complete an NOE with his new employer.

Unpaid leave or reduction in hours

General leave policies

PEBA does not dictate the employment status of an employee, only the coverage that is available to the employee through PEBA's programs. **While on paid leave, an employee's eligibility for benefits continues, and the employer should pay the employer's share of any premiums during the paid leave.**

This section describes how eligibility for insurance benefits is affected when an employee goes on an employer-approved leave of absence that is not associated with military leave or FMLA. See the Unpaid leave quick reference on Page 186 for more information.

Employees with unpaid leave or reduction of hours

Ongoing employees

Any employee employed during the Standard Measurement Period (October 4-October 3) is an ongoing employee. Eligibility for benefits is based

on the number of hours the employee worked during the Standard Measurement Period.

If the employee averaged 30 hours per week during the Standard Measurement Period, he is in a Stability Period and a reduction in hours (even to zero) does not make the employee ineligible for benefits. As long as the employee remains employed with the employer, his eligibility for benefits continues for the remainder of the stability period.

Provide the employee with the [Your Insurance Benefits When Your Hours are Reduced](#) form, which is under Insurance Benefits/Forms/Affordable Care Act (ACA). The employee's benefits will continue and the employee cannot cancel coverage unless one of the following occurs:

- The employee experiences a special eligibility situation such as a gain of other coverage. In this case, the benefits administrator should submit an NOE or SOC with the supporting documentation.
- The employee intends to enroll in coverage through the Health Insurance Marketplace. In this case, the benefits administrator should submit the [Active Termination Form](#) to PEBA using EBS. All active termination forms should be submitted using EBS except for those who are on military leave. Check the box in the Reduction of hours section and sign. Because the employee is voluntarily terminating coverage, neither the employee nor his covered dependents are eligible for COBRA. Once the employee cancels his active coverage, the employee may not re-enroll in benefits until the next open enrollment period, if eligible, or within 31 days of a special eligibility situation.

If the employee did not average 30 hours per week during the Standard Measurement Period, he is not in a Stability Period and a reduction in hours of less than 30 per week makes the employee ineligible for benefits.

Provide the employee with the [Your Insurance Benefits When Your Hours are Reduced](#) form.

Because the employee's hours have been reduced, the employee is no longer employed in a benefits-eligible position. Eligibility for benefits ends the first of the month following the reduction in hours.

Provide the employee with the 18-month COBRA Notice and, if enrolled in life insurance, the PEBA Coverage Verification Notice of Group Life Insurance. Submit the [Active Termination form](#) to PEBA. Check the T5 box, Not Eligible (Not in a Stability Period.)

New full-time Employees (Not Employed for the Standard Measurement Period)

These employees are not in a Stability Period. A reduction in hours of less than 30 per week makes the employee ineligible for benefits.

Provide the employee with the [Your Insurance Benefits When Your Hours are Reduced](#) form.

Because the employee's hours have been reduced, the employee is no longer employed in a benefits-eligible position. Eligibility for benefits ends the first of the month following the reduction in hours.

Provide the employee with the 18-month COBRA Notice and, if enrolled in life insurance, he will receive a conversion packet from MetLife.

Variable-Hour, Part-time, or Seasonal Employees (Within an Initial Stability Period)

If the employee averaged 30 hours per week during his Initial Standard Measurement Period, he is in his Initial Stability Period and a reduction in hours (even to zero) does not make the employee ineligible for benefits. As long as the employee remains employed with his employer, the employee remains eligible for benefits through the end of his Initial Stability Period.

Provide the employee with the [Your Insurance Benefits When Your Hours are Reduced](#) form. The employee's benefits will continue and the employee cannot cancel coverage unless one of the following occurs:

- The employee experiences a special eligibility situation, such as a gain of other coverage. In this case, the benefits administrator should submit an NOE or SOC with the supporting documentation.
- The employee intends to enroll in coverage through the Health Insurance Marketplace. In this case, the benefits administrator should complete the [Active Termination Form](#).

Once the employee's Initial Stability Period ends, he becomes an ongoing employee and continued eligibility should be based on his hours worked during the Standard Measurement Period (October 4-October 3). Refer to Ongoing Employees section on Page 57.

Premiums while on unpaid leave

Only employees who are within a stability period or employees who are absent from work due to FMLA or military leave may continue their coverage with their employer when their hours are reduced below 30 per week. All other employees lose eligibility for benefits when their hours are reduced below 30 hours per week, and these employees should be offered COBRA continuation coverage. The benefits administrator should submit the Active Termination Form to PEBA.

Eligible employees are only responsible for paying the employee's share of the premium while on unpaid leave. All premiums should be paid to the employer by the first of the month. If an employee fails to pay his employer by the first of the month, the employer can cancel his coverage due to nonpayment by submitting an Active Termination form to PEBA.

If an employer fails to submit an Active Termination form to terminate coverage due to nonpayment within the month payment is due, coverage will be terminated the first of the month after request.

There is a 31-day grace period for employees to make payment and have coverage reinstated. If the

employee makes payment before the end of the grace period, the benefits administrator can submit a Request for Review form to PEBA requesting the employee's coverage be reactivated, because the employee submitted payment within the payment grace period. Coverage will be reinstated retroactively to the termination date.

Cancellation due to non-payment is not a COBRA qualifying event. No COBRA notice should be sent to the employee or his covered dependents. The employee may not re-enroll in benefits until the next open enrollment period, if eligible, or within 31 days of a special eligibility situation. **Please note: Returning to work is not a special eligibility situation that allows an employee to re-enroll in benefits.**

SLTD and life insurance benefits while on unpaid leave

- SLTD benefits will end 31 days after last day worked. Complete an *Active Termination Form* to terminate employee's SLTD coverage. Under Section C, Plan and Dates, mark SLTD only and list the effective date.
- Life Insurance benefits end 12 months after last day worked. Complete an Active Termination Form to terminate employee's life coverage. Under Section C, Plan and Dates, mark, as appropriate, Dependent Life/Child, Dependent Life/Spouse and/or Optional Life. List the effective date.

Continuing MoneyPlus while on unpaid leave

If the employee remains eligible for benefits, and he decides to continue his MoneyPlus contributions to his spending accounts, he can only continue until the end of the calendar year in which he begins unpaid leave. There are three ways to manage an employee's spending account elections during unpaid leave:

1. **Prepay.** The employee is given the opportunity to prepay his contributions on a pretax basis.

- **Health Savings Account** — the same rules apply to contributions to the employee's HSA.
2. **Pay-as-you-go.** The employee is given the opportunity to pay with after-tax and/or pretax dollars (to the extent the employee receives compensation during leave).
- Collect the contributions from the employee and include the money with the deposit covering the active employee contributions for any given payroll period.
 - The employer must send payroll funding and participant remittances to ASIFlex via ACH or mail to P.O. Box 6044 Columbia, MO 65205-6044.
 - **Health Savings Account** — Employees may also contribute directly to their HSAs through Central Bank on an after-tax basis. If they choose to do this, there is nothing for the employer to report.
3. **Catch-up.** The employee and the employer agree that the employer pays the contribution on the employee's behalf during leave, and the employee repays the employer upon return. Provisions for catch-up are between the employer and the employee. This must be decided prior to leave. PEBA assumes no liability for this option.
- **Health Savings Account** — This does option not apply.

If the employee remains eligible for benefits, and he decides not to continue his MoneyPlus contributions:

- Notify ASIFlex via the employer portal that the person is on unpaid leave and will not be continuing his contributions.
- Notify ASIFlex via the employer portal when the person returns from leave if his contributions will resume.

If the employee's unpaid leave makes him ineligible for benefits, refer to Page 85 regarding the procedures for terminating participation in MoneyPlus accounts.

Military leave

The Uniformed Services Employment and Reemployment Rights Act (USERRA) requires employers to provide certain reemployment and benefits rights to employees who serve or have served in the uniformed services. The administration of military leave is based on the employer's policy and applicable laws. The general COBRA rules are modified to allow an employer to fulfill the requirements of USERRA when an employee takes military leave. Except as noted below, military leave should be administered as regular unpaid leave.

- At the beginning of military leave (regardless of whether leave is paid or unpaid), an employee may continue or drop all of his coverage.
 - If the employee chooses to continue coverage, the employer must continue to pay the employer share of the premiums for any period of paid military leave and then continue to pay the employer portion as long as the employee is in a stability period.
 - If the employee chooses to terminate coverage, submit the [Active Termination Form](#) and a copy of the military orders to PEBA when the employee begins military leave. An employee on military leave is eligible for a total of 36 months of COBRA continuation coverage. Provide the employee with the 36-month COBRA Notice and, if he is enrolled in life insurance, he will receive a conversion packet from MetLife.
- When the employee returns from military leave, the employee may re-enroll in

coverage within 31 days of returning to work.

- If the employee terminated coverage and he returns to work within 15 calendar days or does not experience a break in coverage, the employee may reenroll in the same benefits he was enrolled in prior to military leave.
- If the employee terminated coverage and he returns to work more than 15 calendar days later or he experiences a break in coverage, the employee may make elections as a new employee.
- An employee returning from military leave may reinstate his life insurance at the same level he had prior to going on military leave without evidence of insurability, regardless of when he returns to employment, as long as he is honorably discharged.
- SLTD coverage may also be reinstated without medical evidence.

If a special eligibility situation occurred while the employee was on military leave, and he did not continue his coverage through PEBA, he may add the newly eligible spouse and/or children when he returns to work by providing documentation of the special eligibility situation.

Family and Medical Leave Act (FMLA)

The Family and Medical Leave Act of 1993 (FMLA) requires qualifying employers to provide job-protected leave, continuation of certain benefits and restoration of certain benefits upon return from leave for specific family and medical reasons. The administration of FMLA leave is based on the employer's policy and applicable laws. In most cases, the employee will not make changes to

benefits and will return from FMLA leave, and no action will be required. However, if he does wish to make changes during FMLA, the following rules allow an employer to fulfill the requirements of FMLA when an employee takes FMLA leave.

Under FMLA, eligible employees of qualifying employers are entitled to 12 work weeks of leave in a 12-month period for:

- Birth of a child and to care for the newborn child;
- Placement of a child with the employee for adoption or foster care;
- Care for a family member (child, spouse or parent) with a serious health condition;
- Their own serious health condition; and
- Any qualifying exigency arising if the employee's spouse, son, daughter, or parent is a covered military member on covered active duty.

Under FMLA, eligible employees of qualifying employers are entitled to 26 work weeks of leave in a 12-month period for:

- An employee who is a spouse, son, daughter, parent, or next of kin of a covered service member with a serious injury or illness to provide care for that service member.

The FMLA regulation 29 CFR section 825.209 Maintenance of Employee Benefits states: An employee may choose not to retain group health plan coverage during FMLA leave. However, when an employee returns from leave, the employee is entitled to be reinstated on the same terms as prior to taking the leave, including family or dependent coverages, without any qualifying period, physical examination, exclusion of pre-existing conditions, etc. See §825.212(c).

During FMLA leave, an employee remains eligible for benefits even if his hours reduce below 30 hours per week and even if the employee is not in a stability period. No action is required by the employer when an employee goes on FMLA leave

unless the employee chooses to cancel his coverage.

If the employee chooses to keep coverage during FMLA leave, the employer must pay the employer share of the premiums for any period of FMLA leave, regardless of whether the leave is paid or unpaid.

- The employer must provide the employee advance, written notice of the terms and conditions under which the employee premium payment must be made if the premiums are not being payroll deducted.
- **There is a 31-day grace period on premium payments.** If the employee fails to make a timely payment within 31 days, the employer may:
 - Pay the employee's share of premium payments for the remainder of the leave period and recover the amount from the employee when the employee returns to work. PEBA assumes no liability for this option.
 - Cancel the employee's coverage. *The employer must give the employee written notice at least 15 days before coverage would end.* PEBA will refund a maximum of 31 days retroactive of premiums.
 - Send an Active Termination Form marked non-payment. If the employee returns to work before FMLA leave is exhausted, the employee may reinstate coverage the first of the month following his return to work. Write on the top of the NOE, Employee returning from FMLA.

If the employee fails to return to work after exhausting FMLA leave, the employer may make the following benefits decisions.

- The employer may allow the employee to continue employment.

- If the employee is on paid leave, benefits continue and no action is required.
- If the employee is on unpaid leave, refer to the Unpaid Leave section beginning on Page 57 to determine if the employee is eligible to continue benefits based on his status (ongoing employee, new full-time, new variable-hour, etc.).
- The employer may terminate employment.
- The employer offers the employee and his covered dependents 18 months of COBRA continuation coverage due to a reduction in hours. The date of the COBRA qualifying event should be listed as the last day of FMLA leave. Even if the employee canceled coverage during FMLA leave, COBRA continuation coverage should be offered at the end of FMLA leave if the employee does not return to work after exhausting FMLA leave.
- See Transfers and terminations (Page 65) and COBRA Subscribers (Page 76) for additional procedures.

If the employee chooses to terminate coverage during FMLA leave:

- Submit an NOE to PEBA refusing all coverage. List change reason as Employee on FMLA.
- Upon return from FMLA leave, most employees are restored to their original or equivalent positions with equivalent pay, benefits and other employment terms.
 - If the employee returns before FMLA leave is exhausted, the employee's coverage should be reinstated on the same terms and conditions without any qualifying period or evidence of insurability.

- The request to reinstate coverage must be made within 31 days of returning to work.
- Write on top of the NOE, Employee returning from FMLA.
- If the employee does not return to work at the end of FMLA leave, the employer should send the employee and his covered dependents the 18-month COBRA Notice. The date of the COBRA qualifying event should be listed as the last day of FMLA leave.

Workers' compensation

Workers' compensation is not administered as unpaid leave. An employee, on approved leave because of disability approved by the Office of Workers' Compensation Programs, **is considered to be drawing a salary from the state.**

- All coverage must continue as before during the benefit period, unless a change in status/special eligibility situation occurs. Documentation may be required.
- The employee pays the employee's share of premiums to the employer's payroll office.
- The employer pays the employer portion of premiums.
 - If the employee has stopped making payments for his share of the premiums, the employer may continue the coverage and request repayment of the employee's share once he returns to work.
 - If the employer does not wish to continue the employee's coverage because he has stopped paying his share of the premiums, the employer should consult with its legal counsel before terminating the employee's coverage.
 - To terminate the coverage, the employer should send an Active Termination Form marked nonpayment. The employee may reinstate coverage within 31 days of

his return to work. Otherwise, he may enroll within 31 days of a special eligibility situation or during open enrollment.

Affordable Care Act reporting requirements

Employers who participate in the State Health Plan have certain requirements under the Affordable Care Act. Employers must provide subscribers with proof of health coverage by issuing forms to subscribers. Each year, the IRS determines the date by which employers must send the forms to subscribers.

Employers with less than 50 employees

- Issue IRS Form 1095-B to any active employees enrolled in health coverage at any time during the previous calendar year.

Employers with 50 or more employees

- Issue IRS Form 1095-C to any employees who were eligible for health coverage at any time during the previous calendar year.

All employers except members of the State Applicable Large Employer (ALE) group

- Issue IRS Form 1095-B to any non-Medicare retirees or COBRA subscribers enrolled in health coverage at any time during the previous calendar year.

PEBA issues Form 1095-B to any non-Medicare retirees or COBRA subscribers for members of the State ALE group. PEBA also issues Form 1095-B for employers who are able to designate PEBA as its Designated Governmental Entity (DGE).

Employers must also submit Forms 1094-B or 1094-C to the IRS. Each year, the IRS determines the date by which to submit these forms.

To assist employers with their reporting requirements, PEBA will post a file on EBS each year that contains information about their employees

and dependents who were enrolled in health coverage at any time during the previous calendar year.

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Transfers and terminations

Transfers and terminations

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Assisting a transferring employee

For PEBA's insurance purposes, a **transfer** is defined as an active employee who moves from one participating employer (losing employer) to another participating employer (gaining employer) with no break in benefits or with no more than a 15-calendar-day break in employment.

An **academic employee**, who completes a school term and moves to another academic setting at the beginning of the next school term, is also considered a transfer, not a new hire. Coverage remains in effect through the summer.

Generally, when he transfers, an employee will remain enrolled in the same insurance benefits.

Transferring out (losing employer)

After the employee notifies you of his intention to transfer to another participating employer without a 15-day break in employment or with no break in insurance coverage, submit the transfer information to PEBA.

- Enter the transfer as a termination in EBS. Select *Transfer* in the Reason for Termination drop-down list. Enter the Transfer Group ID and effective date. EBS provides an Employer Group ID Help feature, or
 - Complete a paper [Active Termination Form](#) and mark the reason for termination as Transfer (TT). Include the gaining employer Group ID and name.

PEBA will produce a transfer form that will be sent to the benefits administrator at the new employer. The transfer form is similar to the benefits statement and lists an employee's benefits and his covered spouse and/or children. The form includes an area for the employee to change his address,

telephone number, Basic Life and Optional Life beneficiaries.

COBRA applies to transfers

COBRA notification for continuation of health, dental and vision coverage must be sent to transferring employees, their spouses and their children.

When an employee transfers, COBRA notification is not required for MoneyPlus accounts. PEBA will notify the MoneyPlus administrator of any transferring employee who has a MoneyPlus account.

Academic transfers

Employees of public school districts, universities, colleges and technical colleges (participating academic employers) are considered academic employees and are subject to the termination and transfer rules below.

These rules apply, regardless of when the benefits administrator receives the resignation.

- Academic employees, who complete a school term and move to another participating academic employer, are considered academic transfers, even though they may not work during the summer.
- The losing academic employer must continue to cover academic transfer employees during the summer, pay the employer share of premiums, collect premiums from the employee and terminate coverage at the beginning of the fall term (September 1) to avoid a break in coverage.
 - Exceptions may be made for academic positions that begin employment during the summer, such as, but not limited to, coaches, principals and superintendents. If you use a NOE, be sure to write the employee's position at the top of the NOE so that the PEBA staff will know this is an exception.

- If *not* transferring or if working for the summer:
 - Academic employees, who are leaving employment and do not plan to transfer to another academic setting, should be terminated effective the first of the month following the last day worked. If an academic employee terminated employment at the start of summer, but returns to an academic setting in the fall, he is still considered a transfer. The employee must pay the back premiums for the summer months to his losing employer to avoid a break in coverage.
- If the academic employee was planning to return to an academic setting in the fall, **but decided to retire retroactively**, he should be terminated effective the first of the month following the last day worked. If the employee is eligible for retiree coverage, but has missed the 31-day window to enroll, he should contact PEBA.
- Academic employees who work during the summer session, **but who are not transferring to another academic setting in the fall**, should be terminated from coverage effective the first of the month following the last day worked.
- The academic employer determines the eligibility status by contract with each employee and position. The summer session may or may not be considered permanent, full-time employment.

- The termination effective date from the losing academic employer should coincide with the effective date of the gaining academic employer, **reflecting no break in coverage.**
- Academic employees who are retiring effective July 1 should be terminated from active coverage July 1.

Permanent, part-time teacher transfers

A permanent, part-time teacher, who transfers from one academic employer to another with no more than a 15-calendar-day break in employment or with no break in coverage, should be considered a transfer and must keep the same coverage. The health and/or dental premium may change if the number of contract hours places the teacher in a different category. He may make changes based on the increase or decrease in hours as explained in the Active Subscribers section of this manual.

Change in status during the transfer

If a change in status event/special eligibility situation occurs, and:

- If the effective date of the change in status event falls before the effective date of the employee's transfer, the employee must contact the losing employer to complete an NOE for the change.
 - Forward the completed NOE, along with any required documentation, to PEBA. PEBA will edit the system and send a new transfer form to the gaining employer.
- If the effective date of the change in status event falls on or after the effective date of the employee's transfer, the employee must contact his new employer to complete an NOE for the change.
- Coverage changes or add/drop a spouse and/or children cannot be completed as part of the transfer.

Transferring in (gaining employer)

Confirm that the subscriber is a transfer from another participating employer:

- You may have received a transfer form from PEBA if the losing employer completed the termination in a timely manner.
 - The subscriber may give you a copy of his termination and/or creditable coverage letter.
 - Contact PEBA if you have any questions about the status and eligibility of the transferring employee.
 - Contact the previous BA or ASIFlex if you have questions about the transferring employee's MoneyPlus status.
- Be sure that the transferring employee is offered the same orientation given to new employees with your group and review the COBRA regulations.
- Documentation, such as proof of dependent eligibility, court orders and incapacitated child certification, is **not** needed if previously established.
- The effective date of the gaining employer should coincide with the termination effective date from the losing employer, reflecting no break in coverage.
 - If the effective date of loss under the losing employer is before the hire date for the gaining employer, but within 15 days, the employee's date of hire should be entered in EBS or on an NOE as the effective date of loss under the losing employer.

Academic transfers

- The termination effective date from the losing academic employer should coincide with the effective date of the gaining

academic employer, **reflecting no break in coverage.**

- He must be enrolled in the same coverage he had previously.
- His previous employer must:
 - Pay the employer share for his coverage, retroactively, for the summer to avoid a break in service, unless the employee works in a position that is an exception as explained on Page 67.
 - Collect the employee share of coverage, retroactively, from the employee and include it with the employer payment.

Enrolling the transferring employee through EBS

When you receive a transfer form from PEBA, complete the transfer in EBS. The transfer form can be uploaded using EBS and submitted with a signature page. All of the employee's information and coverage levels will be prepopulated in the fields. Refer to Page 15 for more information.

Completing the transfer form

The system-generated transfer form will already have your group name and number listed under A, BA USE ONLY section. Have the employee review the form and make any necessary and/or allowed changes. **Do not** make coverage changes or add/drop a spouse and/or children on the transfer form. You can key the transfer using EBS and upload the transfer form with barcode and signature page.

A. BA USE ONLY

- **Effective Date:** Should reflect no break in coverage between employers. Verify there was no more than a 15-calendar-day break in employment or no break in insurance coverage to confirm the transfer status.
- **Annual Salary:** List the annual contract salary with your group. Do not include any additional pay other than the contract salary. Groups affected by furloughs should use the non-furlough salary. This salary will

be used to figure the premium for SLTD if the transfer has SLTD coverage.

- **Employment Date:** First day physically at work.
- **MoneyPlus Indicator:** System will reflect Y, N or Leave Blank. You may need to confirm this with PEBA or the previous benefits administrator.

B. ENROLLEE INFORMATION

Make any mailing address, email address or telephone number changes necessary in this section. The employee should mark a single line through any information that needs to be updated and print the new information.

C. MEDICARE AND OTHER COVERAGE INFORMATION

Coverage through Medicare or another policy for a subscriber, a spouse or child will be shown here.

D. COVERAGE

Coverage and levels will be printed on the form. The employee may make limited changes to his life and SLTD coverage by completing an NOE. See Using an NOE Instead of EBS or a transfer form on Page 71.

E. DEPENDENTS

- The spouse and/or children on file at the time of the transfer from the previous participating employer will be shown in this section. The insurance benefits under which each spouse or child is covered will be indicated beside the spouse or child's name. An X under the benefit will indicate the spouse or child is covered.
- The subscriber will need to correct any spelling of names, dates of birth, SSNs (copy of card required if not a keying error by PEBA), or add any missing information by submitting an NOE.
- A spouse and/or children may not be added to, or deleted from, any benefit, unless a qualifying change in status has occurred.
 - *Exception:* Dependent Life coverage may be added or dropped throughout the year.

F. BENEFICIARIES

The transfer form will list the beneficiaries for benefits as reflected in PEBA's records. **Changes are allowed in this section.** If the subscriber wishes to make a beneficiary change:

- He should mark through the beneficiary (including the asterisk (*) listed on the form), initial the mark-through and write in (or type in) the new beneficiary, including all necessary information, on the first available line.
- He must indicate the benefit (Basic Life, Optional Life) by putting an asterisk (*) in the space under the benefit. If enough space is not available to list the desired beneficiaries, he should write SEE ATTACHMENT in the beneficiary section on the transfer form and staple the attachment to the transfer form. If more than one beneficiary is designated, the employee should indicate the appropriate percentages and whether each beneficiary is primary or contingent.

If the transfer employee has health coverage, a beneficiary for Basic Life must be indicated. If you see that this field on the transfer form is blank, please have the employee fill it in.

G. AUTHORIZATION:

- The employee must sign and date the form.
- The benefits administrator must sign and date the form.
- Make a copy for your files, give a copy to the subscriber and return the original to PEBA for processing.

Change in status during transfer

If a change in status event/special eligibility situation occurs, and:

- If the effective date of the change in status event falls before the effective date of the employee's transfer, the employee must contact the losing employer to complete an NOE for the change.

- That employer must send the completed NOE, along with any required documentation, to PEBA. PEBA will edit the system and send a new transfer form to the gaining employer.
- If the effective date of the change in status event falls on or after the effective date of the employee's transfer, the employee must contact his new employer to complete an NOE for the change.
- Do **not** make coverage changes or add/drop a spouse and/or children on the transfer form.

Using an NOE instead of EBS or a transfer form

Use an NOE instead of EBS or a transfer form when:

- A transfer form is not available.
- The losing employer has not terminated the transferring employee. (If NOE is received before the employee is transferred, it will be rejected.)
- The employee wants to make the following changes to his coverage:
 - **Dependent Life:** The transfer employee wants to add, increase or drop Dependent Life coverage on a spouse and/or child. Evidence of insurability is required to add or increase coverage on a spouse.
 - **Optional Life:** The transfer employee NOT participating in the MoneyPlus Pretax Group Insurance Premium feature wants to increase, decrease or drop coverage. Evidence of insurability is required to increase coverage. Employees currently enrolled in OL, but who are participating in the MoneyPlus Pretax Group Insurance Premium feature, can increase, decrease or drop coverage only during annual enrollment or within 31 days of a change in status.

- **SLTD:** The transfer employee wants to enroll or decrease to a 90-day waiting period with medical evidence of good health. He may also drop SLTD coverage.
- **No changes** may be made for health, Dental Plus, Basic Dental or State Vision Plan coverage.
- A change in status or special eligibility situation has occurred. If you have a transfer form, be sure to attach the completed NOE and any required documentation to the transfer form and send them to PEBA for processing. See Change in status during transfer on Page 70.

If using an NOE, it must be completed in its entirety.

- Check **Transfer** at the top of the NOE, in the Administrative Information (ADM INFO) section.
- The benefits administrator may call PEBA to obtain previous levels of coverage.
- Be sure to complete the SLTD selection under the Benefits section.
- Remember to attach any required documentation listed in Transferring IN, beginning on Page 69.

Transfers — new group created or lateral transfer

New group created by interdepartmental transfers or lateral transfers from one group to another (restructuring)

- Group numbers will change on all files (PEBA insurance benefits, PEBA retirement benefits and all plan administrators) for employees of new employer groups created by interdepartmental/agency reorganizations.
- The same policies and procedures govern employees who are laterally transferred from one employer group to another. This occurs when employees are moved from one agency to another without a break in

coverage or employment because of a management decision within employer groups.

- Each employee affected by the transfer will be terminated from the old group and added to the new group, with no break in coverage and with the same coverage. PEBA insurance benefits' computer transfer function will terminate and add the employees automatically.
- Other coverage changes are permitted only if a special eligibility situation occurs. Documentation may be required.

Old employer group procedures (losing employer)

Before the effective date of the transfer:

- Resolve all rejections for any employees being transferred.
- Process and send to PEBA any eligible changes in status for applicable benefits and coverage or Optional Life changes that occur before the effective date of transfer.
- The employees' names, SSNs, old group ID number and new group ID number with effective date of transfer must be sent to PEBA (address on Page 9). The computer transfer function will be used to transfer this information.
- Give all benefits documentation, including COBRA notification letters, to the new employer at the time of transfer.

New employer group procedures (gaining employer)

- Prepare a letter of notification to PEBA with the following information:
 - Departing employer and group number;
 - New employer and group number;
 - Effective date of change; and
 - SSN and name of each employee being transferred.
- Send the letter of notification to PEBA for processing.

- Send a copy of the notification letter to the losing employer group (to the employer that the employees are leaving/have left).
- Place a copy of the notification letter in each employee's file.

The new employer must process any eligible family status changes that occur after the effective date of transfer.

Transfers — dual employment

Employee working for two participating employers

If an employee is working for two participating employers, he is considered working for one employer or the other for insurance purposes. He cannot be considered working for both employers.

The employee **cannot** have his insurance coverage and premiums split between the two employers, nor may he combine his two salaries for Optional Life/Dependent Life Insurance purposes.

If an employee starts working for a second participating employer and wants his insurance coverage to be with the new employer, he is considered a transfer. He has 31 days to complete an NOE as a transferring employee or to have his transfer processed. If the 31-day window is missed, his coverage remains with the first employer.

The standard procedures for transferring the employee apply, including the procedures for transferring out, transferring in and COBRA notification as explained earlier in this section.

Terminations

General rules for terminating active employees

- Submit terminations in EBS immediately.
- All changes in employment or special eligibility situations resulting in a termination of coverage must be processed within 31 days.
- If submitting a termination outside of the 31 days, complete and send an [Active Termination Form](#).

- Check only ONE reason for termination.

Retroactive terminations

Maximum 31 days retroactive

(To be calculated from the date received by PEBA)

Terminations may be no more than 31 days

retroactive. *Exception:* If PEBA receives an [Active Termination Form](#) that is more than 31 days retroactive, it will be accepted and processed only if it is accompanied by an NOE (such as a COBRA NOE or Retiree NOE) that shows the subscriber is continuing coverage, and with no break in his coverage.

If a termination is received **more than 31 days** from the date of loss of eligibility, PEBA will cancel coverage the first of the month after the date of receipt.

During December, retroactive terminations should be submitted on an [Active Termination Form](#), rather than through EBS, if the subscriber makes a change with an effective date of January 1.

Academic employees

If not transferring or if working during the summer:

- Academic employees, who are leaving employment and do not plan to transfer to another academic setting, should be terminated the first of the month following the last day worked.
- If an academic employee terminated employment at the start of summer, but returns to an academic setting in the fall, he is still considered a transfer. Refer to Academic Transfers on Page 67 for additional information.
- Academic employees who work during the summer session, **but who are not transferring to another academic setting in the fall**, should be terminated from coverage the first of the month following the last day worked.
- The academic employer determines the eligibility status by contract with each

employee and position. The summer session may or may not be considered permanent, full-time employment.

- Academic employees who are retiring effective July 1 should be terminated from active coverage July 1.
- You must refund overpaid premiums if the premiums are deducted on a prorated scale to cover the summer months. Advance deduction of premiums does not constitute continuous coverage.

COBRA notification required

If an employee's coverage is terminated due to leaving employment, a reduction in hours or service or disability retirement, you should notify the employee and dependents, if applicable, of continuation of coverage as a COBRA participant. Refer to the COBRA section for information on COBRA notification procedures.

Termination due to unpaid leave or a reduction in hours

Refer to the Active Subscribers chapter.

Termination due to non-payment of premiums

- Termination is effective the first of the month *following the last month in which premiums were due and paid in full*. If an employee fails to pay his premiums, submit an [Active Termination Form](#) to PEBA as soon as possible. **If a termination is received more than 31 days from the date of loss of eligibility, PEBA will cancel coverage the first of the month after the date of receipt.**
 - If coverage was terminated due to an administrative error, or because the employee subsequently paid the employer within the 31-day grace period, follow the procedures for completing a [Request for Review](#) on Page 136. Otherwise, the employee and any eligible spouse and/or children must wait until the next October enrollment or until a

special eligibility situation occurs and enroll as late entrants.

- Optional employers should complete the appropriate NOE to terminate coverage for retiree, COBRA and survivor subscribers.
- If the subscriber is terminated due to non-payment of premiums, do not send COBRA notification letters, since COBRA does not apply.
- *If the employee returns to work after coverage has been terminated, reinstatement of coverage must be requested within 31 days of returning to work.* Otherwise, the employee and any eligible spouse and/or children must wait until the next open enrollment period or until a special eligibility situation occurs and enroll as late entrants.

(*Exception: State Vision Plan.* Employees can enroll themselves and/or their covered spouse and/or children during the next October enrollment period if they miss their 31-day window of opportunity.)

Other termination information

Life insurance

If terminating employment, the employee may convert his Basic Life, Optional Life, Dependent Life-Spouse and/or Dependent Life-Child coverage to an individual whole life policy. To convert Basic Life, Optional Life, Dependent Life-Spouse and/or Dependent Life-Child coverage to an individual policy at termination of employment, the election must be made within 31 days of the date coverage would otherwise terminate.

MetLife will mail terminated employees a conversion packet via U.S. mail three to five business days after MetLife receives the eligibility file from PEBA. To convert coverage, an employee must follow the instructions in the packet from MetLife. Coverage must be converted within 31 days the date of coverage is lost. It is the

employee's responsibility to contact MetLife regarding conversion.

Long term disability

Basic Long Term Disability may not be continued or converted to an individual policy at termination.

Supplemental Long Term Disability (SLTD) may be converted within 31 days of termination if:

- The individual has had SLTD coverage for at least one year.
- The individual is not disabled.
- The individual is not a retiree.

A [Request for Long Term Disability Conversion Materials](#) is available on the PEBA website.

MoneyPlus

- **Medical Spending Account** — A terminated participant has through the run-out period to submit expenses incurred through the date of termination unless he is continuing participation on an after-tax basis through COBRA.
- If the employee is continuing a Medical Spending Account after termination through COBRA, and the employee has a debit card, the card will be canceled as of the date of termination submitted to PEBA.
 - If the termination is due to the death of the participating employee, the employee's eligible spouse and/or children may elect to continue the MSA coverage through the end of the plan year. In this case, eligible spouse and/or children mean IRS qualified tax dependents as defined in IRS Publication 502. Otherwise, the spouse and/or children have through the run-out period to submit any eligible claims incurred through the date of death.
- **Dependent Care Spending Account** — a terminated participant has until the end of

the year or until the account is exhausted, whichever occurs first, to submit expenses.

- **Health Savings Account** — Health Savings Account participants may continue to contribute to their accounts after terminating employment, so long as they are covered by a high deductible health plan, whether it is the State Health Plan Savings Plan or another high deductible plan offered by another insurer. They cannot be covered by any other type of health plan. Because they have terminated employment, they would contribute on an after-tax basis directly to Central Bank or other Health Savings Account custodian. They can then include these after-tax contributions on their tax returns according to the IRS guidelines.
 - **If the employee decides to close his HSA account.** Closing a MoneyPlus HSA account with Central Bank is a two-step process. Besides the benefits administrator notifying PEBA of the termination from employment, the employee must contact the Central Bank HSA Account Holder customer service line at 866.719.2122. **Do not advise employees to leave their HSA accounts open with a \$0 balance.** If the employee does not close his account with Central Bank, the monthly \$1.25 service charge will continue, resulting in an overdraft, compounded by additional charges. When the account balance drops below \$25, he should use the rest and contact Central Bank to close the account.

Reinstating coverage after termination

If an employee has terminated employment, coverage may be reinstated, if done quickly.

- If coverage was terminated within the past 15 days:
 - Send a letter to PEBA, including reason for reinstatement of coverage. Be sure to include the employee's name, SSN and the effective date for coverage to be reinstated. **Do NOT send an Active NOE or the termination form with Reinstatement written on it.**
- If coverage was terminated more than 15 days ago:
 - The employee is considered a new hire, and coverage cannot be reinstated. Submit an enrollment for the new hire.

Exception: Academic transfers. Send a letter to PEBA, explaining the employee is an academic transfer and include the employee's name, SSN, and effective date of transfer. Be sure to follow the academic transfer procedures explained on Page 69.

Affordable Care Act reporting requirements

Employers who participate in the State Health Plan have certain requirements under the Affordable Care Act. Employers must provide subscribers with proof of health coverage by issuing forms to subscribers. Each year, the IRS determines the date by which employers must send the forms to subscribers. Learn more on Page 63.

The left side of the image features a large, abstract graphic composed of several overlapping, parallel diagonal bands in various shades of blue, ranging from a deep navy to a light sky blue. These bands create a sense of depth and movement, pointing towards the right. The right side of the image is a solid, clean white background.

COBRA subscribers

COBRA subscribers

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What is COBRA?

Consolidated Omnibus Budget Reconciliation Act

COBRA is designed to protect only those individuals (called qualified beneficiaries) who lose their group health, dental and/or vision insurance due to certain qualifying events outlined in the federal law.

Under COBRA, it is the responsibility of the covered employee, spouse or other family member to notify the benefits office within 60 days of a qualifying event.

COBRA regulations require that continuation of group insurance coverage be offered to eligible individuals who lose their group medical coverage due to a qualifying event. These qualifying events are listed in the Qualifying Event Notices that address 18-, 29- and 36-month COBRA continuation.

The following coverage may be continued under COBRA:

- State Health Plan;
- Dental Plus and Basic Dental;
- State Vision Plan; and
- MoneyPlus Medical Spending Account (only through the end of the year). COBRA notification procedures for continuing a Medical Spending Account are different than for health, dental and vision coverage. *Go to Page 85 for COBRA instructions and procedures relating to Medical Spending Accounts.*

Who is the COBRA administrator?

PEBA coined the term COBRA Administrator to identify who collects COBRA premiums and receives notices from COBRA participants.

- For a former employee of an optional employer, the COBRA Administrator is the **optional employer**.
- For any other COBRA participant, the COBRA Administrator is **PEBA**.

Assisting a terminating employee

If the employee is not eligible to retire

- You must offer the employee and his covered spouse and/or children COBRA enrollment information by letter, except:
 - If the termination was due to gross misconduct or non-payment of premiums, the benefits administrator does not need to send COBRA notification letters, since the employee, his spouse and children are not eligible.
 - You may want to consult your legal counsel before making a determination of gross misconduct.
- An employee, whose spouse is also a covered employee or retiree, may apply for health, dental, vision and/or Dependent Life* on his spouse's coverage within 31 days of termination.

**If the spouse is a retiree, Optional Life AD&D and Dependent Life coverage is not available.*

If the employee is eligible to retire

- You must still offer the retiring employee and his covered spouse and/or children COBRA enrollment information by letter, even though he is eligible for retiree insurance benefits.

Required COBRA notices

The required COBRA notices are available on the PEBA's website, www.peba.sc.gov in the Forms section under the Insurance Benefits tab.

Each COBRA notice includes an instruction sheet that summarizes the notification procedures for that particular notice. These instruction sheets are very helpful, so please be sure to read them before you proceed. These notices are available in Microsoft Word format. You can download the forms to your computer and enter the subscriber and COBRA information where prompted.

Benefits administrators are responsible for completing and mailing these COBRA notices:

- [Initial COBRA Notice](#) (send when health/dental/vision coverage begins or when beginning a MoneyPlus Medical Spending Account);
- [18-month COBRA Notice; and](#)
- [36-month COBRA Notice](#).

Mailing requirements for all COBRA notices

- Address the notice to the covered employee and to the spouse for children (if spouse and/or children are covered).
- The first and last names of the covered employee, covered spouse and the covered children MUST be listed in the body of the notification letter. The phrase covered children may be used for children ONLY in the address and salutation portions of the letter.
- Send it to the last known address.
- One notice to the home satisfies the requirement if the spouse and all children live at the same address as the employee.
- Send a separate notice to the spouse and/or children if they live at a different address from the employee.
- Send first class mail.
- Hand delivery to the employee is **not** considered notice to a covered spouse or child. A separate notice should be mailed to the spouse and children if a notice is hand-delivered to an employee.

Initial COBRA Notice

First required notice

Benefits administrator sends this notice

Notice of the right to purchase temporary extension of group health/dental/vision coverage when coverage is lost due to a qualifying event

The intent of the initial notification is to provide a broad summary of the COBRA law, procedures and

obligations to all covered individuals and outline notification responsibilities, including the 60-day notification requirement.

- When coverage begins, send an [Initial COBRA Notice](#) to:
 - A new employee who elects health, dental or vision coverage or a Medical Spending Account for himself and/or his spouse and children.
 - A newly covered spouse or a child of a covered employee, enrolled due to a special eligibility situation.
 - Anyone newly covered at open enrollment.
- Send the initial, written notice to the newly covered employee, spouse or child.
 - Notification is NOT required if the employee, his spouse and children do NOT enroll in a health, dental or vision plan or a Medical Spending Account.
 - After distribution, place a copy of this entire letter in your employee's file.
- If this notice has not been provided to your covered employees, his spouse and children, send a notice immediately.

It is your responsibility to:

- Check the employee file for coverage. If the employee is covered:
 - Check the enrollment for a spouse and children.
 - If the employee has single coverage, address the notification to the employee only.
 - If the employee has family coverage, address the notification to the employee and spouse by name (John and Mary Doe).
 - If no spouse is named, address the notification to John Doe and covered children.

60-day COBRA notification requirement for spouses and children

(Spouses and children must meet this requirement to be eligible to continue coverage under COBRA.)

Under COBRA, the employee, spouse or other covered family member must notify his benefits office within 60 days of the date when coverage would have been lost to be eligible to continue coverage under COBRA.

- This rule applies to all spouses and children enrolled in health, dental and/or vision coverage.
- If a qualifying event is not reported to the benefits office within 60 days of when coverage would have been lost, had it been reported in a timely manner, COBRA rights for that individual(s) are forfeited. In this situation, no COBRA coverage should be offered and no notification should be sent.
- The spouse and children are notified of this 60-day requirement in the initial COBRA notice they receive.

Procedures for determining COBRA eligibility

- Determine if a COBRA-qualifying event has occurred.
- Document the date the benefits administrator is notified of the event.
- Confirm the date the initial notice was mailed and that it included the 60-day notification requirement.
- Calculate the date of loss of coverage had the event been reported in a timely manner.
- Count 60 calendar days from the date determined to be the coverage loss date.
- If the qualifying event was reported within this 60-day period, offer COBRA; if not, DO NOT OFFER COBRA.

- Document the file. If eligible, send [Notice of COBRA Qualifying Event](#); if ineligible, use the [COBRA Ineligibility Form for Dependents](#). The forms are on www.peba.sc.gov in the Forms section under the Insurance Benefits tab.

Example

Qualifying event: ineligible child (child turns 26)	
Date of qualifying event	September 15, 2014
Date BA notified of event	January 20, 2015
Date initial COBRA notice mailed	November 20, 1997
60-day notification language included in notice?	Yes
Date of coverage loss if reported timely	October 1, 2014
60 calendar days from date of coverage loss	November 29, 2014 (60 days from October 1, 2014)
Qualifying event reported within this period?	No
Action	Do not offer COBRA; document file, using the COBRA Ineligibility Form for Dependents.

COBRA Qualifying Event Notice Second required notice

Benefits administrator sends this notice

Notice to eligible qualified beneficiaries of their right to elect COBRA coverage when a qualifying event occurs

The individual must be covered on the day before the qualifying event by the group health, dental and/or vision plan to continue coverage under COBRA. Each individual (including spouses and children) covered under the plan is a qualified beneficiary and has independent election rights. COBRA should **not** be offered to spouses or children who were dropped because of the Dependent Eligibility Audit.

After a qualifying event has occurred, eligible individuals should be notified of their rights to continue health/dental/vision coverage.

If the employee became eligible for Medicare within 18 months before the employee's termination of employment or reduction of hours, the maximum period of COBRA coverage for his covered spouse and/or children is 36 months from the date the employee became eligible for Medicare. This is known as the *Medicare Entitlement Rule*.

Depending on the tobacco-use status before and whether that status has changed for the new COBRA subscriber, a new [Certification Regarding Tobacco and E-cigarette Use](#) form may need to be completed and attached to the [COBRA NOE](#).

Who is a qualified beneficiary?

A qualified beneficiary:

- Must have been covered (under Health, Dental Plus, Basic Dental, State Vision Plan and/or MoneyPlus Medical Spending Account) on the day before the qualifying event; AND
- Must be a **covered employee**, the **covered spouse** of the covered employee or a **covered child** of the covered employee.

Two situations may occur *during the COBRA coverage period* that would cause a child (who was not covered at the time of the qualifying event) to gain the status of a qualified beneficiary. These are:

- A child born to, adopted by, or placed for adoption with, *a covered employee* during a period of COBRA coverage is considered a qualified beneficiary.
- A child receiving benefits pursuant to a Qualified Medical Child Support Order or a National Medical Support Notice, if the support order or notice requires *the covered employee* to provide coverage, is considered a qualified beneficiary.

Not every spouse or child who is added to coverage during the COBRA coverage period would be a

qualified beneficiary, eligible to extend their COBRA coverage if a second qualifying event occurs, such as divorce. *Example:* If a subscriber on COBRA coverage gets married and adds his new wife to his coverage, she is *not* a qualified beneficiary and would not be eligible to extend her coverage to 36 months should the couple divorce one year later.

If a spouse or child is found not to be eligible for coverage due to an audit or other event, the individual is not eligible for COBRA coverage.

Qualified beneficiaries under COBRA are eligible to elect individual health plans if desired, but they must complete separate NOEs.

18-month COBRA qualifying events

- Leaves employment;
- Transfers;
- Retires; or
- Has a reduction of hours (full-time to part-time, strikes, layoffs and leave of absence).
Note: For information about administering COBRA for an employee who goes on a leave of absence, see Page 57.

Extending COBRA coverage to 29 months

The Omnibus Budget Reconciliation Act of 1989 added a provision to COBRA that affects the 18-month continuation period. The intent is to provide additional coverage protection for disabled qualified beneficiaries. If a qualified beneficiary is approved for Social Security disability benefits according to Title II or XVI of the Social Security Act, he is entitled to extend the 18 months of COBRA coverage to 29 months from the date of the qualifying event, so long as these criteria are met:

- The qualifying event must be the covered employee's **termination of employment or reduction of hours**.
- The qualified beneficiary (who may be the covered employee or his spouse or child) must be determined under the Social

Security Act to have been **disabled at any time before or during the first 60 days after loss of coverage**. It is the qualified beneficiary's responsibility to obtain the disability determination from the Social Security Administration.

- The qualified beneficiary **must notify the COBRA administrator of the Social Security disability determination within 60 days after the latest of:**
 - The date of the Social Security disability determination;
 - The date of the qualifying event (i.e., the employee's termination of employment or reduction of hours);
 - The date which the qualified beneficiary loses (or would lose) coverage as a result of the qualifying event; or
 - The date which the qualified beneficiary is informed, through the initial COBRA notice, of the responsibility to provide the notice of disability determination and the procedures for providing such notice to the COBRA administrator.
- The qualified beneficiary must notify the COBRA administrator of the Social Security determination **before the end of the 18-month period following the qualifying event** (i.e., the employee's termination of employment or reduction of hours).
- The extension of coverage to 29 months is not limited to just the disabled qualified beneficiary. *It applies to all individuals who are qualified beneficiaries as a result of the same first qualifying event. This is true even if the disabled qualified beneficiary does not elect to continue or extend coverage under COBRA.*
- **If the disabled qualified beneficiary extends coverage, the COBRA administrator can increase the premium to 150 percent** for all qualified beneficiaries during the extended 11-month COBRA

period. If the disabled qualified beneficiary does not extend coverage, the COBRA premium remains 102 percent.

- A qualified beneficiary, whose coverage is extended, must notify the plan administrator within 31 days if a final determination is made that he is no longer disabled. He should complete and submit to his COBRA administrator a [Notice to Terminate COBRA Continuation Coverage](#), which is on the PEBA website at Insurance Benefits/Forms/COBRA along with the documentation requested on the form. He does not need to complete a COBRA NOE.

Extending COBRA coverage to 36 months

A second qualifying event may occur during the 18- or 29-month period of coverage (i.e., divorce, child becomes ineligible).

- In such a case, the 18- or 29-month period of coverage may be extended to 36 months, *but only for those individuals listed on Page 82.*
- **Second qualifying events must be reported within 60 days of the event and within the original 18- or 29-month period.** The subscriber should complete and submit to his COBRA administrator a [Notice to Extend COBRA Continuation Coverage](#), along with the documentation requested on the form. He does not need to complete a COBRA NOE.

No qualifying event can extend the maximum coverage period beyond 36 months from the date of the first qualifying event, except for military leave.

Second qualifying events are:

- Death of former employee
 - The covered spouse and covered child(ren) are eligible for up to 36 months of continuation coverage.
- Divorce/legal separation

- The covered spouse and covered child(ren) are eligible for up to 36 months of continuation coverage.
- Child(ren) becomes ineligible
 - The covered child(ren) who turns 26 during the original COBRA continuation period is eligible for up to 36 months of continuation coverage.
- Military leave
 - The employee is eligible for up to 36 months of continuation coverage.
- The COBRA subscriber may complete a [Notice to Extend COBRA Continuation Coverage](#) if there has been a second qualifying event that may extend COBRA coverage. He should attach any documentation requested on the form.
- The completed form should be returned to his COBRA administrator.

- The subscriber or an eligible spouse or child(ren) enrolls in Medicare (Part A, Part B or both) *after* COBRA coverage is elected. If the individual has Medicare *and then elects* COBRA, he can take COBRA for secondary coverage. Medicare will be primary.
- After the subscriber has elected COBRA, the subscriber or an eligible spouse or child becomes covered under other group coverage for which there is no exclusion or limitation for any preexisting condition that the individual may have. If the individual *already* has the other coverage when he elects COBRA, he can have both. The plan that covers the subscriber as an employee will be primary to the plan that covers him as a spouse.

The loss of COBRA eligibility applies only to the person who enrolls in Medicare or other coverage. Covered persons who do not enroll in Medicare or other group coverage may continue their COBRA coverage as long as they are otherwise eligible.

To end COBRA coverage, the subscriber completes and submits to his COBRA administrator a [Notice to Terminate COBRA Continuation Coverage](#), along with the documentation requested on the form. He does not need to submit a COBRA NOE.

COBRA Termination Notice

Third required notice

PEBA sends this notice

This notice is sent when COBRA continuation requirements have been met and COBRA coverage is ending (the end of the 18, 29 or 36 months of required continuation coverage).

The benefits administrator **does not** send this notice. PEBA sends this required notice directly to the qualified beneficiaries.

- A Certificate of Coverage is mailed upon termination.
- This notice is sent via first class mail to the last known address.

Other coverage may end COBRA eligibility

Eligibility for health, vision and/or dental coverage under COBRA may end sooner than the periods discussed earlier in this section. Eligibility will also end when:

COBRA election period

- Once the qualifying event notification has been sent, each qualified beneficiary has a period of time during which to make the decision to elect COBRA continuation coverage.
 - The beneficiary has 60 days after the date of loss of coverage or the date the notification of COBRA rights is sent (whichever date is later) to elect to continue coverage under COBRA.
 - During this period, an employer cannot take any action to hurry an election or a waiver of COBRA coverage.

- An election is deemed made on the date postmarked on the NOE that is sent to the COBRA administrator.
- If a qualified beneficiary signs a waiver of COBRA coverage, the waiver can still be revoked at any time during the 60-day election period.
 - However, once a qualified beneficiary has elected COBRA coverage, he cannot waive afterward, even if time remains in the 60-day election period.
- Qualified beneficiaries who are enrolled under COBRA continue with the same health insurance plan. *Exceptions* are:
 - A qualified beneficiary may change *from* the Standard Plan *to* the Savings Plan. Keep in mind that any deductible amounts accrued under the previous plan will *not* carry over to the Savings Plan. A beneficiary who changes to the Savings Plan must meet the full deductible before benefits are payable.

Initial premium payment period

The qualified beneficiary is allowed 45 days, from the date of election, to make his initial payment as explained below. If the 45th day falls on a weekend or holiday, the first payment is due the following business day.

The initial payment must include the COBRA premiums back to the date of the loss of coverage. For example, assume the following:

- Qualifying event: Divorce
- Qualifying event date: May 28
- COBRA start date: June 1
- COBRA election date: July 22
- First payment due: September 5 (if this falls on a weekend or Labor Day, the next business day).

In this example, the first payment must include COBRA premiums for June, July and August.

COBRA coverage will not be activated and claims will not be paid until the initial, 45-day premium payment is received.

- To activate COBRA coverage immediately so benefits can be paid, the initial 45-day premium payment, as described above, must accompany the COBRA NOE. (*Exception:* Optional employers collect the premium payment before submitting the COBRA NOE to PEBA.)

If the amount due is not paid within this period, COBRA coverage can be terminated retroactively, and the subscriber may be liable for any benefits paid during the period.

Following the initial premium payment, subsequent payments are due on the 10th of the month for that month. COBRA subscribers have a 31-day grace period to pay.

- Following the example used above, the premium for September would be due September 10, and the subscriber has until October 10 to pay it. If the subscriber does not make a payment within the 31-day grace period, his coverage is terminated, and he loses all continuation rights under the plan.

Administrative fee for optional employers

PEBA charges optional employers a \$3-per-month administrative fee for COBRA subscribers. This administrative fee may not be passed along to the COBRA subscriber. By law, the maximum premium the COBRA administrator can charge the subscriber is 102 percent of the total premium (employer and employee shares) charged to an active employee. *Exception:* When 18-month COBRA coverage is extended to 29 months, the COBRA administrator

can charge 150 percent of the total premium for active employees (see Page 81).

Benefit changes

Qualified beneficiaries are entitled to the same rights as active employees. These rights include participating in enrollment periods, changing plans, special eligibility situations and adding a newly acquired spouse or children.

COBRA procedures for the MoneyPlus Medical Spending Account

IRS Code Section 125 allows an employee to continue his Medical Spending Account under COBRA if certain conditions are met. The Medical Spending Account can only be continued for the rest of the plan year; employees may not re-enroll for the next year.

- The subscriber must be enrolled in the Medical Spending Account at termination.
- The subscriber must, on a timely basis, elect to maintain continuous contributions, on an after-tax basis to the Medical Spending Account.
- The monthly administrative fee will be added to the amount due.
- COBRA rules allow an additional administrative fee for continuing the Medical Spending Account of two percent of the monthly amount in all cases, except disability. The fee is calculated and included with the payment.

Procedures at termination

- PEBA will send ASIFlex a file to report COBRA qualifying events.
- ASIFlex will then notify the participant of his COBRA rights and include a COBRA Continuation Coverage Election Form.
 - The monthly contribution amount already will be filled in on the form.

- The notification will include information regarding when and how payments should be made.
- When ASIFlex receives the election form from the participant, ASIFlex will process the application and send payment coupons to the participant for future monthly payments. Remember that participants may only continue their Medical Spending Accounts and coverage through the end of the year.
- The participant has 45 days from the date the election is signed to make the initial payment.
 - The initial payment must include the cost of the continuation coverage from the time the coverage would have otherwise terminated, up to the time he makes his initial payment.
 - The monthly contribution amount and the amount of the initial payment will be included in the payment coupons that will be sent to the participant.
- If no payment is received within 45 days, the individual will lose all continuation rights under the plan.
- Subsequent payments are due by the first day of the month coverage is provided. If payments are made on or before the due date, coverage will continue without any break.
- **There is a 31-day grace period for payment. Payments must be postmarked by this date and if ASIFlex does not receive payment by the end of the grace period, coverage will end as of the last paid-through date.**

Benefit administrators with MoneyPlus COBRA questions may call ASIFlex at 833.SCM.PLUS. Employees should be directed to call ASIFlex's Customer Care number at 833.SCM.PLUS.

Affordable Care Act reporting requirements

Employers who participate in the State Health Plan have certain requirements under the Affordable Care Act. Employers must provide subscribers with proof of health coverage by issuing forms to subscribers. Each year, the IRS determines the date

by which employers must send the forms to subscribers. Learn more on Page 63.

COBRA quick reference

Action type	Required COBRA notice
New hire	Initial Notification
Special eligibility situations (<i>adding someone to coverage</i>): <ul style="list-style-type: none"> • Marriage • Birth • Adoption/placement for adoption • Gaining custody • Loss of other coverage 	Initial Notification
Open enrollment (<i>adding someone to coverage</i>): <ul style="list-style-type: none"> • Employee • Spouse • Child(ren) 	Initial Notification
Open enrollment (<i>dropping someone from coverage</i>): <ul style="list-style-type: none"> • Employee • Spouse • Child(ren) 	No notice required, unless due to a qualifying event (separation, divorce or child becomes ineligible).
Gain of other coverage	No letter required
Legal separation	36-Month Qualifying Event Notice
Divorce	36-Month Qualifying Event Notice
Child becomes ineligible	36-Month Qualifying Event Notice
Transfers	Losing employer should send the 18-month Qualifying Event Notice. Gaining employer should send the Initial Notification.
Leaves employment (for reasons other than gross misconduct or non-payment of premiums)	18-month Qualifying Event Notice
Retires	18-Month Qualifying Event Notice
Working hours reduced	18-Month Qualifying Event Notice

The background of the slide features a series of parallel diagonal stripes in various shades of blue, creating a dynamic, geometric pattern that runs from the top-left towards the bottom-right. The stripes vary in width and color intensity, ranging from a deep navy blue to a light sky blue, set against a white background.

Retiree subscribers

Retiree subscribers

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Requirements for retiree insurance

Eligibility for **retirement** is not the same as eligibility for **retiree group insurance**. Determining retiree insurance eligibility is complicated, and only PEBA can make that determination. PEBA recommends an employee review the requirements for retiree group insurance in the Retiree group insurance chapter of the [Insurance Benefits Guide](#) before he confirms his retirement date. Please remember that in addition to qualifying for retirement, an employee's last five years of employment must be served consecutively in a full-time, permanent position with an employer that participates in the state insurance program to qualify for retiree insurance.

PEBA insurance benefits **cannot** confirm eligibility over the telephone. If an employee's anticipated retirement date is **within 90 days**, please direct him to submit an [Employment Verification Record](#) with a [Retiree NOE](#).

If an employee's anticipated retirement date is **three to six months away**, he may submit an [Employment Verification Record](#), along with his anticipated retirement date, and PEBA will give him a written confirmation of his eligibility. PEBA will **not** confirm eligibility for retiree insurance more than six months before an employee's retirement date.

Assisting an eligible retiree

Administrative information

- PEBA acts as the benefits administrator for retirees, except retirees of optional employers. Benefits administrators of optional employers serve as the main contacts for their retirees.
- Retirees do not have to be receiving a retirement check from PEBA to be eligible for retiree insurance. However, they must be eligible for a retirement check and must

meet the retiree insurance eligibility requirements explained in the Retiree group insurance chapter of the IBG.

- Retirees continue to use the same health and dental ID cards (if they do not change plans) and the same *Insurance Benefits Guide*.
- PEBA will send open enrollment information to retirees at their last known address in PEBA's records.

For optional employers only

An optional employer *does not* have to participate in PEBA's retirement program for its qualifying retirees to be eligible to participate in the State Health Plan.

Benefits administrators for optional employers remain the main point of contact for their retirees.

Optional employers determine whether they will pay the employer share of contributions for retirees and survivors. Regardless of funding, retirees must be offered retiree coverage if they meet the eligibility requirements (see the Retiree group insurance chapter of the IBG).

- Optional employers are billed for all retirees and survivors.
- Optional employers collect all premiums for their subscribers.

Benefits administrators for optional employers must verify eligibility for their retirees.

- The [Employment Verification Record](#) (verification of service credit for retirement eligibility) must be attached to the [Retiree NOE](#). Both must be signed by the benefits administrator and returned to PEBA for retirement eligibility verification.
- Optional employer benefits administrators must always sign the *Retiree NOE*, whether the retiree is new or is changing coverage, changing beneficiaries, address, etc.

Notes regarding academic retirees

- If active employee insurance premiums are deducted on a prorated scale to cover the

summer months, you must refund any overpaid premiums that result when a teacher or academic employee retires after the spring semester.

- Advanced deduction of premiums does not constitute continuous coverage throughout summer months, unless the employee is actively working on a full-time basis during that time.

Retiree packet information

These forms are on the PEBA website at www.peba.sc.gov:

- *Retiree NOE*
- *Employment Verification Record* form (This form must be signed by the optional employer benefits administrator and attached to the NOE.)

Important retirement information

Health insurance

The same certification and documentation required of active subscribers, spouses and children applies also to retirees, spouses and children (i.e., eligibility documentation, spouse is a state group employee/retiree, spouse lost coverage, incapacitated child, etc.).

- If the subscriber's tobacco-use status has changed, complete a [Certification Regarding Tobacco or E-cigarette Use](#) form and attach it to the [Retiree NOE](#).

If both the retiree and spouse are covered retirees (or one is a covered employee and the other is a covered retiree) and both persons are enrolled in the same health plan, the family deductible will apply.

- Eligible state retirees must enroll individually. Some exceptions may apply.
- Only one parent can enroll a child. However, one parent can cover the child

under health and the other parent cover the child under dental.

When the retiree becomes eligible for Medicare

Applies also to covered spouses and children

Due to age:

- PEBA will notify the retiree, in advance of his 65th birthday, to complete the appropriate paperwork and make elections. If the retiree is enrolled in the Standard Plan or Savings Plan, his coverage will change automatically to the Medicare Supplemental Plan when he turns age 65 and becomes eligible for Medicare, unless he completes and returns the paperwork, within 31 days of Medicare eligibility, to stay on his current plan.
- Advise your retirees to enroll in Medicare Parts A and B when they become eligible so that they will have optimal coverage.
- Eligibility for the GEA TRICARE Supplement Plan will end.

Due to disability/before age 65:

- The retiree or covered spouse or child must notify PEBA within 31 days of becoming eligible for Medicare due to disability or due to end-stage renal disease and submit a copy of his Medicare card to verify eligibility.
- When an individual begins dialysis for end-stage renal disease, he becomes eligible for Medicare three months after beginning dialysis. At this point, he begins a "coordination period" of 30 months. During this time, his coverage through the State Health Plan remains primary. When the coordination period ends, Medicare becomes primary. The coordination period applies whether the subscriber is an active employee, retired, a survivor or a covered spouse or child, and regardless of whether the subscriber was already eligible for

Medicare due to another reason, such as age.

- Eligibility for the GEA TRICARE Supplement Plan will end.

Medicare Part D

State Health Plan members enrolled in Medicare are eligible for Express Scripts Medicare, a group-based, Medicare Part D Prescription Drug Plan (PDP). PEBA has determined that most subscribers covered by the Medicare Supplemental Plan or the Standard Plan will be better served if they remain enrolled in this Medicare Part D plan sponsored by PEBA.

- Each fall, before Medicare's annual enrollment period, PEBA is required to send a notice to subscribers who are eligible for Medicare, notifying them of their options.
- If a Medicare-eligible subscriber or his eligible spouse or child enrolls in a Medicare Part D plan not sponsored by PEBA, he will lose his prescription drug coverage through his plan with PEBA, and his health insurance premiums will not decrease.
- Most individuals enrolled in Medicare who have coverage through PEBA should not enroll in a separate Medicare Part D plan. Under Part D, the federal government offers a program to help pay monthly premiums and a program to help pay copayments/coinsurance for people with limited resources. To apply for limited income assistance, individuals can complete an application online at www.socialsecurity.gov or call the Social Security Administration at 800.772.1213.

Medicare Supplemental Plan

For Medicare-eligible retirees enrolled in the Medicare Supplemental Plan:

- Claims will be paid according to the Standard Plan provisions for covered family members who are not eligible for Medicare.
- The private duty nursing deductible starts with the effective date of Medicare

Supplemental coverage, even if the yearly deductible under the previous plan (Standard Plan, etc.) has already been met.

Dental insurance

- The retiree group dental coverage is the same as the active group dental coverage.
- The retiree may elect dental coverage, even if he refuses health coverage.

Vision insurance

- The State Vision Plan benefits are the same as for the active group.
- The retiree may elect the State Vision Plan, even if he refuses health coverage.

Life insurance

If retiring, the employee may continue or convert Optional Life. He may only convert his Basic Life, Dependent Life-Spouse and/or Dependent Life-Child coverage to an individual whole life policy. MetLife will mail a conversion/continuation packet via U.S. mail three to five business days after MetLife receives the eligibility file from PEBA.

To continue coverage, the retiree must complete the form that will be included in his packet from MetLife. Coverage must be elected within 31 days of the date coverage is lost due to approved retirement or approved disability retirement.

To convert coverage, an employee must follow the instructions in the packet from MetLife. Coverage must be converted within 31 days of the date coverage is lost due to approved retirement or approved disability retirement. It is the retiree's responsibility to contact MetLife regarding conversion.

Death benefits within 31 days after retirement

- If an employee/retiree, his spouse or his child dies within the 31-day period in which he is entitled to have a conversion and/or continuation policy issued, the amount of

group life insurance the employee, his spouse or his child was eligible to continue or convert will be paid to the designated beneficiary. The benefits administrator completes and submits the claim to MetLife using MetLink at

<https://portal.metlink.com/MetLinkPortal/jsp/index.jsp>. More on filing life insurance claims is in the Claims and appeals chapter.

- If death occurs after the 31-day period, benefits will not be paid, unless the employee submitted an application and paid the premium for the conversion/continuation.
- In the case of a living benefit, the remaining percentage can be continued through the continuation or conversion provision, if the employee is retiring due to service or disability. If the employee is not retiring due to service or has not been approved for disability by The Standard or PEBA, the remaining percentage can be converted. Refer to the IBG for information on the living benefit and continuation of life insurance in retirement.
- Premiums for continued or converted coverage are due by the payment due date.
 - If the individual is billed monthly, his policy will be canceled 60 days from the billing date of the first unpaid or partially paid bill. Approximately 10 days after the first bill's due date, MetLife will bill again. The due date will be 21 days later. If neither of these bills are paid in full, the individual's coverage will cancel on the 60th day.
 - If the individual is billed quarterly, semi-annually or yearly, his policy will be canceled 60 days from the billing date of the first unpaid or partially paid bill. The individual will not receive another bill or a reminder notice.

Basic Life

Basic Life coverage may be converted within 31 days of retirement to an individual policy through MetLife. The employee should follow instructions in the packet he receives from MetLife if he is interested in converting coverage.

Optional Life

Coverage may be *continued* (continued into retirement as a term policy with no cash value) within 31 days or *converted* within 31 days of retirement to an individual whole life policy through MetLife.

(Note: Accidental death and dismemberment coverage is available only to active employees; it cannot be continued into retirement.) The subscriber may also choose to split this coverage and continue a portion as a term policy and convert a portion to an individual policy. If the retiree does not continue his coverage, he *cannot* re-enroll later (e.g., during open enrollment or if a special eligibility situation occurs). You may want to make a note in his file if he does not want to continue or convert this coverage.

Retirees with questions about their life insurance coverage may call MetLife at 888.507.3767.

To continue Optional Life coverage as term insurance:

- The minimum amount of coverage that can be continued is \$10,000.
- The employee should follow instructions in the packet he receives from MetLife if he is interested in continuing coverage.
- Coverage must be continued within 31 days of the date coverage is lost due to approved retirement or approved disability retirement.

To convert to an individual policy:

- The employee should follow instructions in the packet he receives from MetLife if he is interested in converting coverage.

- Coverage must be converted within 31 days of the date coverage is lost due to approved retirement or approved disability retirement.

Dependent Life

Dependent Life coverage may be *converted* to an individual policy through MetLife. If the retiree does not continue coverage, he *cannot* re-enroll his spouse or children later (e.g., during open enrollment). He also cannot add a new spouse or child to Dependent Life coverage later if a special eligibility situation occurs. You may want to make a note in his file if he does not want to convert this coverage.

- The spouse or child must be covered when the employee leaves employment.
- The 31-day rule applies to continuing life insurance into retirement.
- The employee should follow instructions in the packet he receives from MetLife if he is interested in converting coverage.
- Coverage must be converted within 31 days of the date coverage is lost due to approved retirement or approved disability retirement.

Long term disability

Basic Long Term Disability and Supplemental Long Term Disability may not be continued or converted to an individual policy at retirement.

MoneyPlus

Flexible spending accounts

Generally, a retiree cannot continue to participate in MoneyPlus in retirement, except:

- A Medical Spending Account participant may *continue coverage on an after-tax basis*, under COBRA, through the end of the plan year (as explained in COBRA chapter). As an alternative, a terminated employee or retiree can waive COBRA coverage and elect to prepay all remaining contributions on a pretax basis in order to continue coverage

through the end of the plan year.

Otherwise, the retiree cannot use his Medical Spending Account after he leaves employment and cannot access any remaining funds.

- Refer to the IBG for specific eligibility information regarding the Pretax Group Insurance Premium feature and the Dependent Care and Medical Spending Accounts.

Health Savings Account

If a retiree is not eligible for Medicare and is continuing coverage under the Savings Plan or other high deductible health plan, he may continue to contribute to his Health Savings Account (HSA). Refer to the IBG for more information on HSA eligibility.

- A retiree cannot contribute to his HSA on a pretax basis through MoneyPlus.
- He can contribute directly to Central Bank, custodian for the MoneyPlus HSA, or to another HSA custodian.

Assisting a new retiree with enrollment

Retirees may enroll in and add or drop their spouse or children from health, vision and/or dental coverage within 31 days of the date of retirement. Many of the procedures for completing a [Retiree NOE](#) are the same as those outlined in the Active Subscribers chapter. Below are some reminders for completing the Retiree NOE.

Completing the Retiree NOE

Refer to the instructions on the back of the NOE. Be sure to use this form when enrolling a retiree. **Do NOT use an Active NOE**, regardless of whether you write “Retiree” across the top of it.

Eligibility

- Check type of retiree (regular, disability, police, etc.).

- Provide years, months and days of service. Must attach a completed [Employment Verification Record](#).

If applicable,

- Check whether there is a 5-14-year, 15-24-year, or age 55/25-year and corresponding end date.
- Employers other than state agencies and school districts: Benefits administrator *must* sign verification of retirement eligibility.
- Benefits administrators of optional employers must verify retirement eligibility for their employees, both on the NOE and on the [Employment Verification Record](#). Benefits administrator *must* sign verification of retirement eligibility.

Action

- Indicate type of action requiring NOE. Select only one.

Enrollee information

- Retiree completes blocks #1-16, including **County Code**.

Coverage

- Retiree completes blocks #17-20. If refusing coverage, must check Refuse.

Medicare

- Retiree completes block if any family members to be covered are eligible for Part A or B of Medicare. Retiree must provide a copy of his Medicare card.

Dependents

- #22 — Indicate whether spouse is also a covered employee or retiree. List spouse and all children to be covered and whether they are full-time students or incapacitated.

Certification and authorization

- #23 — Have retiree read this section. Be sure the retiree signs and dates this section.

NOE reminders

- Altered NOEs are not acceptable (no strike-throughs, etc.).
- Photocopies of NOEs are not acceptable.
- Do not use highlighters on NOEs.
- The retiree is wholly responsible for the information on the form(s) he signs.
- Forward original to PEBA with employment record.

Changing coverage in retirement

Regular rules for coverage changes during open enrollment apply.

If a retiree does not pay his complete bill, **all of his coverage** will be canceled effective the last day of the month in which he paid his premiums in full. This includes all premiums for health insurance (including the tobacco-use premium, if applicable), Dental Plus, Basic Dental and the State Vision Plan. Benefits that require no retiree contribution (i.e., Basic Dental) are included in this cancellation policy. The retiree may re-enroll in coverage within 31 days of a special eligibility situation or during an open enrollment period.

Retiree returns to work

If an employee, who is covered under the state retiree group, returns to an insurance-eligible position, he must return to active coverage status or refuse all PEBA coverage.

- If the employee, his eligible spouse or any of his children are eligible for Medicare, he must be offered active group coverage. See Medicare on Page 95 for additional information.
- A part-time teacher who is not eligible for Medicare may choose to stay on retiree group insurance coverage.
- Optional Life (OL)
 - If the retiree has continued OL coverage, he must decide whether

to keep his continued coverage or cancel it and enroll in OL as an active employee. If the retiree elects to enroll in OL coverage as an active employee, he must contact MetLife to cancel his continued retiree coverage due to his return to active status. A return-to-work retiree cannot keep his continued policy and elect OL coverage as an active employee.

- If a retiree has converted OL coverage, he may keep the converted policy and enroll in OL as an active employee. In the event of a claim, both policies would pay, provided the premiums are paid.
- Since Dependent Life (DL) coverage must be converted at retirement, if the retiree returns to work and enrolls as an active employee, he is not required to drop any converted DL coverage to enroll his spouse and/or children in DL as an active employee.
- Retirees returning to work should review their current life insurance coverage and needs carefully before deciding how much coverage they need.

Medicare

If an employee (including a part-time teacher), his eligible spouse or any of his children are eligible for Medicare, the employee:

- Can change to one of the active group plans. Medicare will be secondary payer to the active group coverage. The employee must notify Social Security that Part B will be the secondary payer to his active coverage.
- Can refuse PEBA health insurance coverage altogether (he must disenroll) and keep his Medicare coverage. However, you cannot offer an incentive for the employee to refuse active group coverage.

When the employee leaves active employment and his active group coverage is terminated, he will be eligible to return to retiree group coverage. He must file an enrollment form to return to the state retiree group within 31 days of termination.

In addition, he must notify Social Security that he is no longer covered under an active group, so Medicare can become his primary payer or so he can re-enroll in Medicare Part B during the special enrollment period, if Part B was canceled. The cost of Part B will not go up. Call the Social Security Administration at 800.772.1213 for questions.

Affordable Care Act reporting requirements

Employers who participate in the State Health Plan have certain requirements under the Affordable Care Act. Employers must provide subscribers with proof of health coverage by issuing forms to subscribers. Each year, the IRS determines the date by which employers must send the forms to subscribers. Learn more on Page 63.



Survivors

Survivors

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General rules about survivor coverage

A survivor is a spouse or child(ren) on the coverage of an active employee or retired subscriber who has died.

- A survivor can continue health, dental and/or vision benefits as long as he is eligible.
- If Dependent Life-Spouse and/or Dependent Life-Child coverage was in place when the subscriber died, that coverage can be converted within 31 days.

If survivor was not covered at the time of death

Survivors must be enrolled in health, dental and/or vision coverage at the time of death to be eligible to continue that coverage as a survivor.

- A surviving spouse or child who is not covered when the covered employee or retiree dies is not eligible for coverage as a survivor.
- The survivor will not be eligible to enroll later during open enrollment, nor will he be eligible to enroll due to a special eligibility situation.

If survivor was covered at the time of death

A surviving spouse or child(ren), who is enrolled in health, dental and/or vision coverage when the covered employee or retiree dies, is eligible to continue that coverage as a survivor. The survivor can only continue the coverage he had at the time of covered employee or retiree's death. He may change health plans within 31 days of gain of coverage as a survivor. The survivor may add other coverage during open enrollment or within 31 days of a special eligibility situation such as loss of other coverage.

- If the covered surviving spouse or covered child(ren) terminates health, dental and vision coverage, he loses his eligibility for coverage as a survivor. He will no longer be eligible to re-enroll during open enrollment, nor will he be eligible to enroll otherwise due to a special eligibility situation.
- If the covered surviving spouse or covered child(ren) terminates health, dental or vision coverage later, but he still retains at least one of the other coverages, he keeps his eligibility for coverage as a survivor. He will then be able to re-enroll in the other coverage during open enrollment or when a special eligibility situation occurs.
- A surviving spouse may add an eligible child to coverage during open enrollment or when a special eligibility situation occurs.

Survivors of deceased active employees are classified as survivor subscribers under the retiree group.

Assisting a survivor

- If applicable, notify PEBA retirement benefits regarding the death and any refund or monthly benefit that may be due.
- Complete an [Active Termination Form](#), [Retiree NOE](#) or [Survivor NOE](#) (depending upon the status of the deceased) to terminate the coverage as soon as the death is confirmed, and forward it, along with a copy of the death certificate/documentation, to PEBA insurance benefits immediately.
 - If the deceased was killed in the line of duty, attach verification to the NOE.

If the deceased was an active subscriber

- If the deceased was enrolled in SLTD and receiving benefits at the time of death, call The Standard to report the death for any

potential benefits payable to eligible survivors.

- Any BLTD benefits remaining unpaid will be paid to the employee's estate. Any SLTD benefits remaining unpaid will be paid to the person(s) eligible to receive the survivor benefit that is defined in the SLTD policy. In case there are no eligible survivors as defined in the SLTD policy, survivor benefits would not be paid, and any SLTD benefits remaining unpaid would then be paid to the employee's estate.
- If the deceased was enrolled in Optional Life and/or enrolled in a health plan, file for life insurance with MetLife, using the *Life Insurance Claim Form*. See Page 101 for more information. You can also file using MetLink online at <https://portal.metlink.com/MetLinkPortal/jsp/index.jsp>.
- If the deceased had a MoneyPlus Health Savings Account (HSA), advise the survivor/beneficiary to call Central Bank to settle the account. Central Bank will require proof of death for the deceased and identification for the beneficiary.
- MoneyPlus Medical Spending Accounts (MSAs) and Dependent Care Spending Accounts (DCSAs) are not refundable to the survivor. These accounts are terminated effective the date of death of the employee, unless the IRS-qualified spouse, children or beneficiaries elect to continue the MSA under COBRA through the end of the plan year.

Procedures to continue coverage as a survivor

Benefits administrators must notify survivors about enrollment, cost of premiums, premium collection, coverage changes and terminations.

- When PEBA receives the termination form or NOE, PEBA will notify any covered survivors that health coverage may be continued at no cost for one year (if eligible for the premium waiver) or by paying survivor premiums.
- A [Survivor NOE](#) must be completed within 31 days of the subscriber's date of death. If, as a result of the death, the tobacco-use status for the survivor has changed, complete and attach a [Certification Regarding Tobacco or E-cigarette Use](#) form.
- Since the original subscriber is deceased, the survivor will receive new ID cards from the carriers that will show a new BIN. See also Which SSN/BIN to Use for Claims on Page 100.
- PEBA will bill for continuation of dental and vision coverage if the survivor was covered.
- Optional employers are responsible for premium collection.
- The survivor may pay premiums:
 - Through deduction from a monthly PEBA retirement benefit check;
 - By automatic bank draft; or
 - By direct billing.
- For any children covered by the deceased subscriber, if both parents were covered as active employees or retirees:
 - Health: Remember to add children to the surviving parent's health plan within 31 days of the ending date of the premium waiver.
 - Dental: Add children to the surviving parent's dental plan within 31 days of the loss of coverage under the deceased's plan.
 - Vision: Add children to the surviving parent's State Vision Plan coverage within 31 days of the loss of coverage under the deceased's plan.

Premium waiver rules

- A spouse and/or child must be enrolled in the State Health Plan, under the deceased employee's or employer-funded retiree's coverage, at the time of death to be eligible for coverage and the one-year waiver of premium for health insurance.
 - The premium waiver applies only if there was an employer premium contribution. This includes survivors of employees who work at least 20 hours a week, if the employer has elected the 20-hour threshold. Optional employers may elect, but are not required, to waive the health premiums for survivors of retirees. Survivors not eligible for the waiver may continue coverage by paying the full survivor premiums. Refer to the IBG for additional information on survivor coverage.
 - Survivors of deceased permanent, part-time teachers are not eligible for the premium waiver.
- The waiver of health premium is effective the day after the date of death.
- A surviving spouse is not entitled to a premium waiver if he feloniously or intentionally kills his active or retired spouse.
- After the one-year waiver, survivors must pay the full cost to continue health coverage.
 - *Exception:* If the deceased was killed in the line of duty while working for a participating employer, the surviving spouse or child(ren) may continue coverage, as long as he is eligible, at the employer-funded rate after the waiver ends. (Optional employers may elect, but are not required, to fund this survivor coverage. Survivors not eligible for employer-

funded premiums may continue coverage by paying the full survivor premiums.)

- There is no premium waiver for Dental Plus, Basic Dental or the State Vision Plan. However, the survivors can continue coverage by paying survivor premiums.
 - *Exception:* If the deceased was killed in the line of duty while working for a participating employer, the dental premiums of a surviving spouse or child(ren) will be waived for the first year after the employee's death.
- All policies and procedures apply to survivors during the premium waiver period (i.e., changes due to family status changes, open enrollment, gaining coverage as an employee of a participating employer, etc.).
- PEBA notifies survivors when the waiver period ends and when plan policies and procedures change. The benefits administrator receives a copy of the notification sent to survivors of participating optional employers.
- Survivors may drop health coverage within 31 days of the waiver end date. Otherwise, they must wait until open enrollment or a special eligibility situation allows them to do so.

Which SSN/BIN to use for claims

- Continue to file claims for services provided to the deceased employee or retiree under his SSN or BIN.
- Effective the day after the date of death, the subscriber ID number for the surviving spouse and children is the surviving spouse's SSN or BIN (if the surviving spouse is covered). A BIN will be generated for the surviving spouse.
 - If coverage is for children only, the subscriber ID number is the SSN or BIN of the youngest child, unless Medicare covers one of the

- children. Then, the subscriber ID number is the SSN or BIN of the child with Medicare. A BIN will be generated for the youngest child or the child with Medicare coverage, whichever is applicable.
 - New ID cards with the new BIN on them will be issued by the carriers.
- For any children covered by the deceased subscriber, if both parents were covered as active employees or retirees:
 - **Health:** During the waiver period (if applicable), claims for the covered children should be filed using the SSN or BIN of the child (if there is more than one child, this would be the ID number of the youngest child).
 - **Dental:** Dental claims should be filed using the surviving parent's SSN or BIN.
 - **Vision:** State Vision Plan claims should be filed using the surviving parent's SSN or BIN.

Notes regarding Optional Life benefits for survivors

Once MetLife receives the completed [Life Insurance Claim](#), a certified death certificate, and copies of the NOEs to establish a history of coverage increases, MetLife will determine eligibility and pay the life insurance proceeds and any accidental death and dismemberment benefits, if applicable, such as:

- Accidental Death Benefit (based on the death certificate);
- Seat Belt and Air Bag benefit (based on the police report and/or accident report);
- Dismemberment benefits (based on the accident report);
- Felonious Assault Benefit (based on the police report/death certificate);

- Day Care Benefit (paid to beneficiaries, younger than age 7, who are enrolled in day care); and
- Dependent Child Education Benefit (paid to qualified beneficiaries).

Note: Copies of NOEs are not required if filing with MetLink at

<https://portal.metlink.com/MetLinkPortal/jsp/index.jsp>.

- MetLife also offers legacy planning resources and beneficiary financial counseling. The subscriber may assign benefits to a third party, such as a funeral home. However, MetLife will not be bound by an assignment of the certificate or of any interest in it unless it is made as a written statement, and the subscriber files the original instrument or a certified copy with MetLife's home office, and MetLife sends the subscriber an acknowledged copy. For more information, contact MetLife or see the IBG.
- More information on life insurance claims is in claims and appeals, beginning on Page 130.

When survivor coverage ends

- The surviving spouse's eligibility to continue health/dental/vision coverage as a survivor ends upon remarriage. Survivor coverage ends the first of the following month. Continuation of coverage under COBRA must be offered. The 36-month COBRA continuation period starts when eligibility for survivor coverage ends, regardless of when the survivor notifies his COBRA administrator (PEBA or the benefits administrator, if an optional employer).
Example: Surviving spouse remarries but fails to notify his COBRA administrator for 12 months. He is eligible for COBRA

coverage for the remaining 24 months (36 months - 12 months = 24 months).

- Eligibility for survivor coverage also ends if a surviving spouse or child(ren) becomes eligible for coverage as an active employee with a participating employer.
- He cannot remain on survivor coverage; he must enroll as an active employee.
 - Even if the survivor is still on waiver status, he must enroll as an active employee and pay the employee share of the premium unless he is the survivor of an employee who was killed in the line of duty. However, any covered children who are not employed with a PEBA insurance benefits-participating employer may remain on the waiver until it ends. For additional information and enrollment/payroll instructions, call PEBA's Customer Contact Center at 803.737.6800 or at 888.260.9430.
 - He may return to survivor coverage when he leaves employment or

continue coverage as a retiree, if eligible. He must enroll in survivor or retiree coverage within 31 days of when his active coverage ends. The remainder of the waiver period would not apply.

- A child may continue coverage until no longer eligible. Coverage ends the first of the following month after he becomes ineligible.
 - Children who become ineligible must be offered COBRA. The 36-month COBRA continuation period starts when eligibility for survivor coverage ends, regardless of when the survivor notifies his COBRA administrator (PEBA or the benefits administrator, if an optional employer). *Example:* Surviving child becomes eligible for employer-sponsored group health coverage, but fails to notify his COBRA administrator for 12 months. He is eligible for COBRA coverage for the remaining 24 months (36 months - 12 months = 24 months).

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**Spouses and
children**

Spouses and children

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Spouses: special eligibility requirements and changes in status

Documentation is required to cover a spouse. Any document provided as proof of dependent eligibility (such as a marriage certificate or a birth certificate) that is in a language other than English must be completely translated into English and should be certified with a letter of accuracy from the translator. If a subscriber does not have a translation and wishes to submit a copy of the document, PEBA will try to provide a translation. If PEBA cannot adequately translate the document, the subscriber will be mailed a letter advising him that he is responsible for providing an acceptable English translation.

The eligibility of spouses and children is subject to review. The subscriber will be required to submit documentation proving eligibility of his covered spouse and children. If he fails to submit the required documentation, the dependents will be removed from coverage.

Changes in coverage should be consistent with the change event.

Example: An employee who gets married would normally ADD his new spouse to his coverage, NOT terminate his own coverage unless he is gaining other coverage through his new spouse.

The type of change should be specific, such as Divorce vs. Drop Spouse.

In general, eligible spouses must be added to coverage within 31 days of the special eligibility situation. Otherwise, spouses and children may be added to coverage during open enrollment. The subscriber must be on the plan or added with the spouse and/or child(ren).

Ineligible spouses must be dropped from coverage within 31 days of the event that makes them ineligible for coverage.

Details and exceptions are outlined in each of the situations that follow.

Both spouses employed by participating employers

- If legal spouses are employed by participating employers and eligible for coverage as employees, neither may be covered as a dependent spouse once gaining eligibility as an employee. When a spouse gains eligibility for benefits with a participating employer (even if the spouse refuses coverage), he or she may not continue to be covered under the spouse's insurance. When PEBA receives an enrollment for a covered spouse, PEBA will notify the benefits administrator by letter to submit an NOE to terminate the spouse's coverage. If the employee fails to submit the NOE promptly, PEBA will automatically terminate coverage for the spouse.
- A spouse is not required to carry the same health coverage. However, family deductibles will not apply unless they elect the same health plan.
- Two employees cannot cover the same child(ren) under the same benefit (health, dental, vision, Dependent Life).

Spouse gains coverage as an employee of a participating employer

If a spouse gains state benefits as an employee, he is not eligible to be on the subscriber's coverage and must be dropped from coverage.

- *Effective date to drop spouse from subscriber's coverage:* the date spouse's employee coverage with PEBA insurance benefits begins.
- *Exception:* If a spouse goes to work as a part-time teacher with a participating employer, he may be covered as an employee or a spouse, but not both.

Spouse is retiree subscriber

A spouse who is also an employer-funded retiree is not eligible for coverage as a spouse; a spouse who is not an employer-funded retiree is eligible.

Spouse gains coverage as a retiree subscriber

If a spouse gains state benefits as a retiree, he is not eligible as a spouse and must be dropped from the subscriber's coverage.

- Effective date to drop spouse from subscriber's coverage: the date the spouse's retiree coverage begins.

Marriage

- *Effective date of coverage:* date of marriage for health, dental and vision coverage. Optional Life and Dependent Life-Spouse coverage begins on the first of month following date of request if employee is actively at work (if not actively at work, effective date is first of month following return to work). Dependent Life-Child coverage begins the first of the month after the date of request.
- The eligible employee may enroll himself, existing eligible dependents, his new spouse and new stepchildren in health, vision and/or dental coverage within 31 days of date of marriage. If the employee is already enrolled in health, he may change plans if he is adding his spouse or stepchild to health. The employee may also add Dependent Life-Child, Dependent Life-Spouse (\$10,000 or \$20,000 without evidence of insurability) and Optional Life (up to \$50,000 without evidence of insurability). The employee also may be able to make changes to his Medical Spending Account or Dependent Care Spending Account.
 - A marriage license or Page 1 of the employee's federal tax return is required to add a spouse.

- A birth certificate (long form) showing the name of the natural parent plus proof natural parent and subscriber are married are required to add a stepchild.

- The employee must be on the plan or added with the spouse and/or children.
- *Note about premiums:* If the employee is enrolled in the MoneyPlus Pretax Group Insurance Premium feature, premiums must be paid post-tax for retroactive coverage back to the date of marriage. Premiums may be paid pretax beginning the first of the month following the date of the request.

Spouse of foreign national employee

- *Effective date:* the date they entered the U.S. to *add*; the date they left the U.S. to *drop*
- A spouse of an eligible foreign national employee, working for a participating employer, may be added to health, dental, vision and Dependent Life coverage within 31 days of arrival in the U.S.
 - A copy of the visa/visa stamp, showing the arrival date and a copy of a marriage license are required to add the spouse.
- A spouse of an eligible foreign national employee, working for a participating employer, may be dropped from coverage within 31 days of departure from the U.S.
 - A copy of the visa/visa stamp, showing the departure date, is required to drop the spouse.

Separated spouse

Subscribers who are enrolled in MoneyPlus **may not drop coverage** for a separated spouse during the plan year, regardless of court order. However, a court could order the separated spouse to pay the subscriber for his share of the premiums instead. Subscribers enrolled in MoneyPlus must wait until

open enrollment, until the divorce is finalized or until another special eligibility situation occurs to drop a separated spouse.

For subscribers who are not enrolled in MoneyPlus:

- Effective date to drop spouse: the first of the month after the date of request on the change.
- To drop a spouse at separation, a copy of a court order signed by the judge is required. The order must state that the divorce is in progress and be included with the change.
- The subscriber has 31 days from the date of the court order's date stamp from the Clerk of Court to drop the separated spouse.
- If the subscriber is dropping the separated spouse from health-related coverage (health, dental or vision), he must drop the separated spouse from all three programs. The subscriber may drop or keep Dependent Life-Spouse.
- If the subscriber fails to drop the separated spouse within 31 days of the date on the order, the subscriber must wait until open enrollment, until the divorce is finalized or until another special eligibility situation occurs to drop the separated spouse.
- The employee may enroll in or increase Optional Life coverage up to \$50,000 without evidence of insurability or cancel or decrease his Optional Life coverage. To do so, an employee must submit an NOE to his benefits administrator within 31 days of the court order date. Changes to Optional Life coverage begin on the first of month following date of request if employee is actively at work (if not actively at work, effective date is first of month following return to work).
- The separated spouse may remain on health, dental, vision and/or Dependent Life-Spouse until the divorce is final. No documentation is required to continue coverage during separation.

Reconciliation

Reconciliation is NOT a special eligibility situation. If a separated couple reconciles:

- The deleted spouse and/or children must wait until the next open enrollment period to be reinstated for health insurance and State Vision Plan coverage.
- The spouse may re-enroll in Dependent Life-Spouse year-round by providing evidence of insurability and being approved. Dental coverage may be reinstated only during the next open enrollment period of an odd-numbered year or within 31 days of a special eligibility situation.

Former spouse/divorce

When a divorce is final, the subscriber must drop the former spouse from all benefits.

- Effective date to drop spouse from subscriber's coverage: first of the month after the divorce becomes final.
- Exception to 31-day rule: If the subscriber fails to drop the former spouse within 31 days of the divorce, the effective date will be the first of the month after the request is made (subscriber's signature date on the NOE).
- A copy of the entire divorce decree must be submitted to confirm the drop in coverage.
- The eligible employee may enroll in or increase Optional Life (up to \$50,000 without evidence of insurability). The employee also may be able to make changes to his Medical Spending Account or Dependent Care Spending Account.

Required to cover former spouse by divorce decree or court order

Effective January 1, 2018, if a divorce decree or court order requires an employee or retiree to continue to cover a former spouse under the State Health Plan, the former spouse is required to have their own policy at the full cost of the premium. The

employee or retiree is thus permitted to cover a current spouse as a dependent under his policy. The employee is eligible to participate in the MoneyPlus Pretax Group Insurance Premium feature.

- *Effective date of former spouse coverage* is the first of the month after the divorce becomes final.
- A former spouse should enroll within 31 days of the date the court order or divorce decree is signed.
- A copy of the entire divorce decree or court order, signed by the judge, must be attached to the [Former Spouse NOE](#).
- The divorce decree or court order must state that the employee is directed to provide insurance.

Death of covered spouse

- Effective date to drop spouse: the day after date of death.
- Exception to 31-day rule: If the subscriber fails to make the request to drop the spouse within 31 days, the request to change the level of health, dental, vision and Dependent Life (if applicable) may be changed retroactively, up to 12 months.
- The subscriber may decrease or drop his Optional Life coverage within 31 days of his spouse's death.

Dependent Life-Spouse coverage

Eligibility requirements

The employee is the beneficiary for proceeds from Dependent Life-Spouse insurance. Spouses enrolled in Dependent Life are covered for Accidental Death and Dismemberment benefits. They are eligible for the Seat Belt and Air Bag benefit, Child Care benefit and Dependent Child Education benefit.

The employee must enroll the spouse in Dependent Life-Spouse coverage within 31 days of first eligibility or within 31 days of loss of other coverage

through a participating employer, or evidence of insurability will be required. Evidence of insurability is required if:

- Requested coverage is greater than \$20,000.
- The spouse is not added within 31 days of initial eligibility, which is:
 - Date of hire, if spouse is not an eligible employee;
 - Date of marriage; or
 - Date spouse is no longer eligible as an active employee. (Note: A spouse, who is a retiree subscriber, may be covered on Dependent Life-Spouse as a spouse within 31 days of the date he retires or during a specified enrollment period.)
- Follow the same procedures as outlined under Optional Life on Pages 51-54 for submitting evidence of insurability.
- The Actively at Work requirement and the Dependent Non-confinement Provision, as explained in the IBG, apply.

Children: special eligibility requirements and changes in status

Documentation is required to enroll a child. Any document provided as proof of dependent eligibility (such as a marriage certificate or a birth certificate) that is in a language other than English must be completely translated into English and should be certified with a letter of accuracy from the translator. If a subscriber does not have a translation and wishes to submit a copy of the document, PEBA will try to provide a translation. If PEBA cannot adequately translate the document, the subscriber will be mailed a letter advising him that he is responsible for providing an acceptable English translation.

The eligibility of spouses and children is subject to review. The subscriber will be required to submit

documentation proving eligibility of his covered spouse and children. If he fails to submit required documentation, the dependents will lose coverage.

Changes in coverage should be consistent with the change event.

Example: An employee who has a baby would normally ADD his new baby to his coverage, NOT terminate his own coverage.

The type of change entered in EBS should be specific, such as Child gains employment with coverage vs. Ineligible child.

Special eligibility situations allowing an employee or retiree to enroll himself only (if not already enrolled) or enroll himself and his eligible child(ren) in health, vision and/or dental insurance: **marriage, birth, adoption/placement for adoption, placement of a foster child, gaining of legal custody, other court order or loss of other coverage.**

Eligible children must be added to coverage within 31 days of the special eligibility event. Otherwise, they may be added during the next open enrollment period. They can be added to State Vision Plan coverage during the next October enrollment period.

Child younger than age 26

A child who is younger than age 26 is eligible if either:

1. The child is the *employee's* natural or adopted child, stepchild, foster child or child for whom the *employee* has legal custody.
2. The employee is required to provide health insurance because of a court order.

The subscriber must submit proof of the child's relationship to the subscriber within 31 days of enrollment and at other reasonable times.

Birth

A newborn may be added to coverage within 31 days of the date of birth.

- *Effective date:* date of birth of the newborn for health, dental, vision and Dependent Life-Child coverage. Optional Life and Dependent Life-Spouse coverage begins on the first of month following request if employee is actively at work (if not actively at work, effective date is first of month following return to work). Newborns are covered under Dependent Life-Child automatically for 31 days from live birth; an NOE must be submitted in EBS to continue Dependent Life-Child coverage beyond 31 days. This can also be completed in EBS.
 - If the 31-day window to add the newborn is missed, the subscriber has 90 days (from the date on the rejection letter if the NOE is submitted after 31 days, or 90 days after the initial 31-day window) to send a written explanation and request for reconsideration to PEBA.
 - If the subscriber misses the 31-day window and 90-day appeal period explained above, coverage may be provided only from the date of birth through the end of the month after the first 31 days. To process claims for this 31 days of coverage, PEBA will need an NOE to add the infant for claims payment for the first 31 days and another NOE to drop coverage, effective the first of the month after the 31-day period. The request/NOEs to add and then drop may be submitted retroactively, up to 12 months.
- The eligible employee may enroll himself, an eligible spouse, existing eligible dependents and the newborn in health, vision and/or dental coverage. If the employee is already enrolled in health, he may change plans if he is adding his spouse or newborn to health. The employee may also add Dependent Life-Child, Dependent

Life-Spouse (\$10,000 or \$20,000 without evidence of insurability) and Optional Life (up to \$50,000 without evidence of insurability). The employee also may be able to make changes to his Medical Spending Account or Dependent Care Spending Account.

- A birth certificate (long form) showing the subscriber as the parent is the preferred document to add the newborn. However, if the child needs immediate service before the birth certificate can be obtained and the provider will not render services without proof of insurance, PEBA will accept an official document from the hospital signed by the attending physician or other hospital staff. The document must include the child's name, date of birth and parents' names.
- A marriage license or Page 1 of the subscriber's current federal tax return is required to add the spouse.

The subscriber must be on the plan or added with the spouse and/or newborn.

Adoption/placement for adoption (child younger than age 18)

A child younger than 18 may be added to coverage within 31 days of the date of adoption/date of placement for adoption.

- *Effective date:* date of birth for health, dental, vision and Dependent Life-Child coverage if baby is adopted or placed for adoption within 31 days of birth (if adopted or placed for adoption after 30 days of birth, effective date is date of adoption or placement for adoption). Optional Life and Dependent Life-Spouse coverage begins on the first of month following date of request if employee is actively at work (if not actively at work, effective date is first of month following return to work).

- *Exception: International adoptions.* The effective date of coverage on the NOE must be either:
 - The date of adoption on the adoption paperwork (this documentation is required). Attach the documentation to the NOE.
 - The date the child entered the U.S. A copy of the visa/visa stamp is required if using this date as the effective date of coverage.
- If the adopted child is a newborn, please see Birth section on Page 109 for additional requirements if the 31-day window to add the child is missed.
- The eligible employee may enroll himself, an eligible spouse, existing eligible dependents and the newly adopted child in health, vision and/or dental coverage. If the employee is already enrolled in health, he may change plans if he is adding his spouse or newly adopted child to health. The employee may add Dependent Life-Child, Dependent Life-Spouse (\$10,000 or \$20,000 without evidence of insurability) and Optional Life (up to \$50,000 without evidence of insurability). The employee also may be able to make changes to his Medical Spending Account or Dependent Care Spending Account.
 - Acceptable documentation to add the newly adopted child includes a copy of a birth certificate (long form) listing the subscriber as the parent; a copy of legal adoption documentation from a court, verifying the completed adoption; or a letter of placement from an adoption agency, an attorney or the Department of Social Services (DSS), verifying the adoption is in progress.
 - A marriage license or Page 1 of the subscriber's current federal tax

return is required to add the spouse.

The employee must be on the plan or added with the spouse and/or newly adopted child.

Custody or guardianship

A subscriber who gains custody or guardianship over a child may add the child within 31 days.

- Effective date: date of custody or guardianship for health, dental, vision and Dependent Life-Child coverage.
- The eligible employee may enroll himself only or any eligible spouse and/or child with new legal custody in health, vision and/or dental coverage. The employee may add Dependent Life-Child for eligible children (**a foster child is not eligible for Dependent Life coverage**). The employee also may be able to make changes to his Medical Spending Account or Dependent Care Spending Account.
 - Acceptable documentation to cover a child with new legal custody includes a court order or other legal documentation from a placement agency or the S.C. Department of Social Services, granting custody or guardianship of a child/foster child to the subscriber. The documentation must verify the subscriber has guardianship responsibility for the child and not merely financial responsibility.
 - A marriage license or Page 1 of the subscriber's current federal tax return is required to add the spouse.
- The employee must be on the plan or added with the spouse and/or newborn. If the employee is already enrolled in health, he may change plans if he is adding his spouse or child with new legal custody to health.
- Note about premiums: If the employee is enrolled in the MoneyPlus Pretax Group

Insurance Premium feature, premiums must be paid post-tax for retroactive coverage back to the date of gaining custody or guardianship. Premiums may be paid pretax beginning the first of the month following the date of the request.

Divorce decree or court order

A child may be added to coverage. The child should be added to coverage within 31 days of the decree/court order.

- *Effective date*: first of the month after the court orders date stamp from the Clerk of Court.
 - If the subscriber fails to drop the separated spouse within 31 days of the date on the order, the subscriber must wait until open enrollment or until another special eligibility situation occurs to add the child(ren).
- A copy of the entire divorce decree or court order must be attached to the NOE or submitted in EBS.
 - The document should state what insurance the employee is directed to provide (i.e., health, dental, vision), and it must list the name(s) of those to be covered. Only the coverage listed in the document may be provided for the child(ren).
 - Former stepchildren are not eligible and may not be covered, even if it is specified in the court order. If a court order directs a subscriber to provide life insurance on his former stepchild, the employee must get a private policy.
- Special eligibility rules do not apply to National Medical Support Notices (NMSNs). See Page 44 for more information about NMSNs.

Child of foreign national employee

- *Effective date:* first of the month after arrival in the U.S. to *add*; first of the month after departure from U.S. to *drop*.
- A child of an eligible foreign national employee, working for a participating employer, may be added to health, dental, vision and Dependent Life coverage within 31 days of arrival in the U.S.
 - A copy of the visa/visa stamp, showing the arrival date, and a copy of a birth certificate (long form) showing the subscriber as the parent are required to add a child.
 - A copy of the visa/visa stamp, showing the arrival date, a copy of a birth certificate (long form) showing the name of the natural parent and proof that the natural parent and subscriber are married are required to add a stepchild.
- A child of an eligible foreign national employee, working for a participating employer, may be dropped from coverage within 31 days of departure from the U.S.
 - A copy of the visa/visa stamp, showing the departure date, is required to drop the child.

Child gains employment with coverage

A child who becomes eligible for other employer-sponsored group health coverage as an employee or as a spouse can continue his coverage through the subscriber. The subscriber may drop the child within 31 days of when the child becomes eligible for coverage through his employer or his spouse's employer.

- *Effective date to drop child:* first of the month after gaining coverage.
- If the child loses his insurance coverage through his employer — *and the child is otherwise eligible for coverage through the subscriber*, the child may be re-enrolled within 31 days of the event or during the next open enrollment period.

A subscriber may cover a child who is eligible for state benefits because he works for an employer that participates in PEBA. However, if the child is covered under his parent's insurance, he is only eligible for benefits offered to children. The child is not eligible for Basic Life, Optional Life, Dependent Life-Child or Long Term Disability insurance.

A child who is eligible for benefits because he works for a participating employer must choose to be covered by his parents as a child, or he may be covered on his own as an employee. He cannot be covered as a child on one insurance program, such as health, and then enroll for coverage as an employee on another, such as vision.

If the child wants to continue coverage as a dependent, he should complete an Active NOE refusing coverage. Under Type of Change on the NOE, next to Other, *specify Enrolled as child of PEBA subscriber*.

If the child later decides to enroll in coverage as an employee, rather than as a dependent, he should complete an Active NOE.

Death of covered child

- Effective date to drop child: the day after date of death.
- Exception to 31-day rule: If the subscriber fails to make the request to drop the child within 31 days and this is the last eligible child, the request to change the level of health, dental, vision and Dependent Life (if applicable) may be changed retroactively, up to 12 months.

Incapacitated child

An incapacitated, unmarried child who is incapable of self-sustaining employment because of mental illness, retardation or physical handicap and who is principally dependent (more than 50 percent) on the covered employee, retiree, survivor or COBRA subscriber for maintenance and support is eligible if:

- The child is covered at the time of incapacitation and has been continuously

covered by a health insurance plan from the time of incapacitation;

- The child remains unmarried; and
- The incapacitation is established no earlier than 90 days before the child's 26th birthday but no later than 31 days after his 26th birthday. For the child to be covered under Dependent Life-Child, the incapacitation is established no earlier than 90 days before the child's 19th birthday but no later than 31 days after his 19th birthday or within 31 days of loss of student status. PEBA determines whether the child is eligible to be considered for incapacitated child status.
- If establishing incapacitation within 31 days of loss of student status for Dependent Life-Child coverage, the subscriber must submit a completed [Incapacitated Child Certification](#) form and attach:
 - A copy of the letter of withdrawal from the educational institution, verifying full-time student status up to the date of incapacitation; and
 - A copy of the latest tax return, verifying the child is principally dependent on the subscriber. Tax schedules do not need to be included, and the tax return may be redacted as necessary.

Coverage for an incapacitated child may continue beyond age 26, when coverage would otherwise end, as long as the child remains eligible (this does not apply to children covered under COBRA). PEBA reserves the right to require the subscriber to submit satisfactory proof of such incapacity and dependency at any time. This proof is typically required within 31 days of initial enrollment, upon attaining age 26, and at other reasonable times, but not more frequently than annually.

A child who becomes incapacitated after age 26 is not eligible.

Incapacitated child certification procedures

If a covered child will turn age 26 within 90 days or the child is ages 19-25 and covered under Dependent Life-Child and incapable of attending school full-time, *and* if the child is incapacitated due to a mental or physical disability, the subscriber should:

Complete an [Incapacitated Child Certification](#) form and send it to PEBA for a determination of eligibility.

- If establishing incapacitation at age 26, this form should be sent to PEBA no earlier than 90 days before the child's 26th birthday and no later than 31 days afterward.
- If establishing incapacitation due to loss of student status for Dependent Life-Child coverage, attach a copy of the letter of withdrawal from the educational institution, verifying full-time student status up to the date of incapacitation, to the [Incapacitated Child Certification](#) form.
- Be sure to complete and attach an [Authorized Representative Form](#), signed by the incapacitated child, to confirm permission for PEBA to discuss or disclose the child's protected health information to the particular person who acts as the child's Authorized Representative.

If the child is incapable of signing the Authorized Representative Form, PEBA may accept, instead, documentation verifying the representative's authority to act on behalf of the child in these matters (i.e., guardianship papers or a power of attorney).

Note: The *Authorized Representative Form* is on the PEBA website.

1. PEBA will forward the completed forms to Standard Insurance Company for a review of the medical information provided, as well

as the terms of the plan of benefits, and a recommendation.

2. The Standard may request additional information from the subscriber and/or the child's health care providers.
3. The Standard will forward its recommendation to PEBA, which makes the final determination based on the recommendation and documentation provided.
4. PEBA will then issue a written approval or denial to both the benefits administrator and the subscriber. (Under HIPAA, no personal health information is disclosed to the benefits administrator.) This minimal notification to the benefits administrator is for the purpose of any potential payroll adjustment.
5. If the child's eligibility as incapacitated is denied, the subscriber can appeal the decision by writing to PEBA within 90 days of receipt of the denial letter. If the denial is upheld by PEBA, the subscriber has 30 days from receipt of the denial letter from PEBA to seek judicial review as provided by S.C. Code Ann. 1-11-710 and 1-23-380. For more information regarding the appeals process, please see Page 136.

Completing the *Incapacitated Child Certification* form

The subscriber must complete and sign Section A and the shaded areas of Section B.

If the child is ages 19-25, attach a copy of the letter of withdrawal from the educational institution, verifying full-time student status up to the date of incapacitation.

The dependent's physician must complete the remainder of Section B and sign Page 4.

The subscriber returns the completed form to PEBA for review, approval/denial and processing.

The subscriber should also complete and attach an [Authorized Representative Form](#), signed by the

incapacitated child. If the child is incapable of signing, PEBA may accept, instead, documentation verifying the representative's authority to act on behalf of the child in these matters (i.e., guardianship papers or a power of attorney).

PEBA will notify the employer and the subscriber of its decision. If eligibility as an incapacitated child is denied, the subscriber has 31 days to submit additional medical records and documentation to The Standard for review and reconsideration. The subscriber may be required periodically to recertify the child's incapacitation.

Child in full-time military service

A child in full-time military service is not eligible for Dependent Life Insurance.

Child turns age 26

Unless the child is approved to continue coverage as an incapacitated child, the child must be dropped from the subscriber's coverage.

Effective date to drop child: first of the month after the child's 26th birthday. The child will be dropped from the system automatically, and any ineligible claims will not be paid.

Dependent Life-Child coverage

Eligibility requirements

The employee pays one premium to insure all covered children listed on the NOE or in EBS, and the employee is the beneficiary for all covered children. There are no accidental death or dismemberment benefits for Dependent Life-Child. Newborns are covered under Dependent Life-Child automatically for 31 days from live birth; an NOE must be submitted to continue Dependent Life-Child coverage beyond 31 days. This can also be completed in EBS.

To be eligible for coverage, the child must be:

- Unmarried.

- Supported by the subscriber (however, a foster child is not eligible for Dependent Life coverage).
- Younger than 19 years old; or at least 19 years old but younger than 25 and a full-time student, not employed on a full-time basis; or any age while incapacitated (certification of incapacitation is required).
- A child who is ages 19-24 and enrolled in and attending school in a full-time student status may be eligible for Dependent Life coverage as a full-time student.
 - School includes: high school, college or university (including graduate school), accredited technical, vocational or trade school or academic military academy.
 - Full-time student status is defined by the institution.
 - The student must be working toward a diploma or degree. Internet classes do qualify, provided they are offered through a school as defined earlier.
 - The child may be added to Dependent Life coverage within 31 days of when he becomes a full-time student. *Effective date:* first of the month after attaining full-time student status.
 - For students already covered, 90 days before a covered child's 19th birthday PEBA will send a letter addressing the child's insurance coverage. The letter will be sent to the benefits administrator via EBS for him to print and mail to the subscriber. The child's coverage will continue unless the subscriber notifies the benefits administrator that the child is no longer a full-time student or incapacitated child. No Dependent Life claims will be paid for children ages 19-24 who

were not eligible as full-time students.

Children may be added or dropped throughout the year, effective the first of the month after request or effective the date of the event if added within 31 days of birth, adoption, etc. No evidence of insurability is required.

- If both plan participants are state employees, only one can carry Dependent Life coverage for eligible children.
- The Dependent Non-confinement Provision applies.

Dependent Non-confinement Provision

If a dependent is hospitalized or confined because of illness or disease on the date his insurance would otherwise become effective, his effective date shall be delayed until he is released from such hospitalization or confinement. This does not apply to a newborn child. However, in no event will insurance on a dependent be effective before the subscriber's insurance is effective.

Eligibility for MoneyPlus spending accounts

A list of who qualifies for reimbursement from a Dependent Care or Medical Spending account is in the [MoneyPlus Tax-favored Account Guide](#), which is on the PEBA website, www.peba.sc.gov. For more information, consult with a tax advisor.

When spouse and children eligibility ends

For a spouse

- A spouse's eligibility ends upon divorce. Coverage ends the first of the month after the divorce becomes final.
- A surviving spouse's eligibility ends at remarriage or if he becomes eligible as an

employee of a participating employer. Coverage ends effective the first of the month after the date of marriage or the first of the month after the date of hire with a participating employer.

- If starting work with a participating employer, the benefit administrators should coordinate when coverage as a spouse ends and coverage as an employee begins to avoid overlapping coverage.
- The subscriber must notify PEBA within 31 days of the event.

For a child

- A child's eligibility for health, dental and vision coverage ends the first of the month after he turns age 26, unless he is covered as an incapacitated child.
- A child's eligibility for Dependent Life-Child coverage ends the first of the month after he turns age 19, unless he is certified as an incapacitated child or is a full-time student. Full-time students are eligible for Dependent Life-Child coverage until they turn age 25.
- If a child is covered as a full-time student and loses full-time student status, eligibility for Dependent Life coverage ends the first of the month after he loses that status.
- The subscriber must notify his benefits office or PEBA within 31 days of the event.

COBRA notification by subscriber required

COBRA notification by the subscriber, spouse or other family member is required within 60 days for spouses and children when eligibility for health, dental and/or vision coverage ends.

Adoption Assistance Program

When funds are available and authorized in the state's budget, it is the policy of the State of South Carolina to provide financial assistance to eligible employees who are adoptive parents of a *special needs child* or other *child*. This program is administered through PEBA.

Qualified applicants will receive:

- Actual adoption expenses, not to exceed \$5,000 for a non-special needs child or \$10,000 for a special needs child.
- When there are not enough funds available or authorized to meet every qualified applicant's expenses, funds will be divided evenly among the applicants (with those who adopted a special needs child receiving twice the amount as those who adopted a non-special needs child).

To be eligible, the adopting employee must be covered by insurance offered by PEBA and must be employed when the adoption is finalized, when the application is submitted and when the payment is made.

Adoption assistance is not available for the adoption of a stepchild or for any other adoption involving a state employee who resides in the same home as the adopted child and the adopted child's parent.

Applications must be submitted July 1 - September 30 for adoptions finalized the previous fiscal year (July 1 - June 30). Following the September 30 deadline, payments will be sent to employees by the end of the following November. *Payments cannot be sent to service providers.*

As it relates to the Adoption Assistance Program, a **child** means any person younger than age 18. A stepchild is not eligible for adoption assistance benefits.

For the purpose of the Adoption Assistance program, a **special needs child**, means a child, as defined above, and who meets other specific requirements set forth in the S.C. Code of Laws. For information on these requirements, contact Traci Rish with PEBA's Insurance Finance department at trish@peba.sc.gov or at 803.734.1628.

Payments will be made to employees for costs related directly to the adoption, such as:

- Medical costs of the biological mother not covered by other insurance, Medicaid or other available resources;
- Medical costs of the child not otherwise covered;
- Licensed adoption agency fees, legal fees and guardian ad litem fees; and
- Allowable travel fees associated with the adoption process.

Adoption assistance is subject to taxes

Financial assistance through the Adoption Assistance Program is subject to federal income and FICA payroll taxes, but is not subject to state income taxes. PEBA will withhold Social Security and Medicare payroll taxes (7.65 percent) from the benefit payment. *These withholdings will be forwarded to the employer.*

- The employer is responsible for the employer payroll tax match. This amount must be reported at the end of the year on the individual's W-2 in Box 3 (Social Security wages), Box 5 (Medicare wages) and Box 12 (using Code T — Miscellaneous Income).
- The employee is responsible for determination and payment of any federal income tax liability.

According to IRS Publication 15-B, *Employers Tax Guide to Fringe Benefits*, an employer must report all qualifying adoption expenses reimbursed to an employee under an adoption assistance program

for each employee. IRS Publication 15-B is available online at www.irs.gov.

Comptroller General (CG) Agencies

If your employer is a CG agency, you are not responsible for reporting FICA taxes for adoption benefits. SCEIS will transfer the employer's FICA match from the STARS account. SCEIS will then forward the employee and employer FICA taxes to the IRS and report the adoption benefit and withholdings on the employee's W-2. A check for the net reimbursement from the Adoption Assistance Program will be issued to the employee, along with a letter explaining the deduction.

For more information or for an application, employees can call PEBA's Customer Contact Center at 803.737.6800 or at 888.260.9430.

The background of the image features a series of parallel diagonal stripes in various shades of blue, creating a sense of movement and depth. The stripes are set against a white background, and the overall composition is clean and modern.

**Disability
subscribers**

Disability subscribers

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Workplace Possibilities

The odds of an employee returning to work after a disability diminish with time. The best chance for an employee to return to work is as soon as possible. The Standard's Workplace Possibilities program may be able to help your disabled employee remain productive.

Stay at Work services are provided while the employee is still working. The goal is to help the employee perform their job tasks. Return to Work services are provided soon after an employee goes out of work. The goal is to quickly return the employee to work.

Learn more about the program [online](#) and sign up for The Standard's blog at www.workplacepossibilities.com/blog.

How can I request services from the Workplace Possibilities team?

The first step is for the employee's manager to discuss the issue with the employee. Then the benefits administrator should submit a [Stay at Work Referral Form](#) and give the employee a one-page [Stay at Work Medical Information Request](#) form for their doctor to fill out and send to The Standard. The employee will also need to complete an [Authorization to Obtain and Release Health Information](#). Once The Standard receives this information, a Workplace Possibilities consultant will contact your employee.

Eligibility

An employee may be eligible for retiree group insurance if he is approved for disability retirement benefits through one of the defined benefit plans administered by PEBA.

Disability retirement eligibility for South Carolina Retirement System members is based on entitlement to Social Security benefits. Police Officers Retirement System disability retirement claims are evaluated by a disability determination provider and a medical board.

State Optional Retirement Program (State ORP) does not provide disability protection. However, a State ORP participant may meet the retirement eligibility requirement for retiree group insurance through approval through The Standard for Basic Long Term Disability and/or Supplemental Long Term Disability. The State ORP participant must also be approved for disability by the Social Security Administration to be eligible for insurance as a disability retiree.

State ORP participants and employees of optional employers who do not participate in a PEBA administered retirement plan may meet the disability retirement eligibility requirements for retiree group insurance through disability approval by the Social Security Administration.

For more information about disability retirement, see Chapter 7 of the PEBA retirement benefits [Covered Employer Procedures Manual](#). For more information about retiree disability insurance see the Disability Retirement section in the Retirement and Disability chapter of the *Insurance Benefits Guide*.

Applying for disability benefits

An employee should apply for disability benefits as soon as he becomes disabled and *before leaving covered employment*. He or she may be eligible for optional life insurance benefits through MetLife and long-term disability through The Standard.

1. Complete and submit an Application for Disability Retirement to PEBA, if applicable.
2. Complete and submit long-term disability information to The Standard, if applicable.
3. Complete and submit optional life insurance information to The Standard, if applicable.

If the employee is unable to file, the employer may file on his behalf. The process may always be canceled, if the employee recovers.

Assisting a disabled employee

If an employee is leaving due to disability:

- Follow the procedures for Terminations. Refer to the Termination Checklists in the Transfers and terminations chapter.
 - COBRA notification rules apply.
 - If eligible for disability retirement, refer the employee to PEBA for assistance and information. This could include filing for disability retirement and establishing any additional service credit. Additional information may be found in the Retiree subscribers chapter.
 - If the employee applied for disability retirement with PEBA before he left covered employment, and he is terminated from employment before he receives approval, he may continue coverage through COBRA. (Note: The employee has 31 days from the date he leaves employment to convert his life insurance with MetLife.) If the employee is later approved for disability retirement, he may apply for retiree insurance within 31 days of the date of notification from PEBA. If the employee does not apply within 31 days of the date of notification, he must wait for a special eligibility situation or open enrollment to enroll as a retiree.
 - If the employee is covered as an active employee until he receives disability approval, he may apply for retiree insurance within 31 days of the date of notification from PEBA. If eligible, retiree coverage will be effective the first of the month following his termination from active coverage, provided he is terminated from active coverage on or after the date of retirement. If the employee does not apply for retiree insurance within 31 days of the date of notification, he must wait for a special eligibility situation or open enrollment to enroll as a retiree. (Note: The employee has 31 days from the date of notification from PEBA to apply for continuation of his life insurance with MetLife. The employee has 31 days from the date of notification from PEBA to apply for conversion of his life insurance with MetLife.)
- Employees who are approved for BLTD/SLTD benefits cannot use that approval to apply for retiree insurance.
 - Explain that the effective date for insurance purposes will be the first of the month following the date on the approval letter from PEBA (disability retirement), or from The Standard (BLTD/SLTD) as explained in the above bullet. The retiree must apply for coverage within 31 days of the date of the approval letter.
 - Review the deductible income/offset rules and overpayment potential for BLTD and SLTD benefits as explained in the Long Term disability chapter of the IBG.
 - If the employee becomes eligible for Medicare as a disability retiree through Social Security, advise the disabled employee he will need to enroll in Medicare Parts A and B. *He must also notify PEBA within 31 days of eligibility.* He will no longer be able to contribute to an HSA if he enrolls in Medicare.
 - If the individual has end-stage renal disease, please read Page 90 in the Retiree Subscribers section for additional information about Medicare's coordination period.

- If the employee does not qualify for retiree insurance benefits, but enrolls under COBRA, he must notify PEBA when he is approved for Social Security disability benefits so that PEBA can determine his eligibility for the 11-month extension of COBRA coverage. Refer to the COBRA chapter for further instructions.

Optional Life

If the employee takes a leave of absence due to a total disability (as determined by the employer), his coverage continues for up to 12 months by paying the premiums, beginning the first of the month after the *last day worked*.

- If employee retires while on the leave of absence, he can choose to continue or convert his coverage within 31 days of leaving active employment, as explained below.
- If the employee dies while on a leave of absence, complete MetLife's [Life insurance claim form](https://portal.metlink.com/MetLinkPortal/js/index.jsp) using MetLink at <https://portal.metlink.com/MetLinkPortal/js/index.jsp>.

If the employee does not return to work at the end of 12 months, terminate his coverage. He should choose to continue or convert his coverage within 31 days of leaving active employment, depending on whether he is eligible to retire. Read Continuation/Conversion below for more information and instructions.

- The employee can be considered eligible for Dependent Life coverage on his spouse's insurance when his eligibility for OL coverage as an employee ends or if he converts coverage. He is not eligible if he chooses to continue his coverage.

Continuation/conversion

- Explain the Optional Life continuation or conversion options, if enrolled. Emphasize the 31-day window.

- If the employee is approved for PEBA retirement benefits disability retirement and/or BLTD/SLTD, but does *not* qualify for retiree insurance benefits, he can still *continue* or convert Optional Life coverage, because he is approved for one or more of these disability programs. The subscriber may also choose to split this coverage and continue a portion as a term policy and convert a portion to an individual policy.
- If the employee is not approved for PEBA retirement benefits disability retirement or BLTD/SLTD, he can only *convert* Optional Life Insurance coverage.
- The procedures for continuing and converting Optional Life Insurance coverage are explained on Pages 91-93.

Accelerated benefits

The accelerated benefits option may be available to active employees on a leave of absence who are terminally ill with a life expectancy of no more than 12 months. Claiming this benefit will reduce the amount of any optional life coverage and will reduce any optional life coverage eligible for continuation or conversion.

Complete MetLife's [Accelerated benefits claim form](#) and submit to MetLife.

Basic Long Term Disability and Supplemental Long Term Disability

Eligibility for benefits

Eligibility for BLTD and SLTD benefits is based upon criteria using terminology from The Standard:

- Own occupation disability (first 24 months).
- Any occupation disability (after 24 months).
- Partial disability.

Note regarding partial disability

An employee may work in another occupation while he meets his own occupation's definition of disability. If the employee is disabled from his own occupation, there is no limit on his earnings in

another occupation. However, the employee's earnings may be deductible income — BLTD/SLTD benefits may be reduced by this income.

BLTD/SLTD claim information

Refer to the Claims and appeals chapter for the procedures for filing claims and appeals. Below is some general information regarding claim documentation.

Satisfactory written proof that the employee is disabled and entitled to BLTD and/or SLTD benefits must be provided. Complete and submit the [Long Term Disability Benefits Claim Form packet](#).

Time limits for filing and substantiating claims

- An employee should submit a completed packet to The Standard as soon as possible, but within 90 days after the end of the benefit waiting period. The Standard will review the *completed claim* upon receipt.
- In situations in which the employee is unable to obtain the information to submit a completed claim to The Standard within the time frame above, The Standard will accept completed claims up to one year after the 90-day period following the waiting period (see above).
- If a completed claim is not filed within one year after the 90-day period following the waiting period, the employee's claim will be denied.
- These time limits do not apply while the employee lacks legal capacity. In this situation, the benefits administrator should contact The Standard for additional information and instructions.

Documentation

- If The Standard asks the employee to provide documentation to complete a claim packet, the employee must provide that documentation within 45 days of The Standard's request. Otherwise, the claim will be denied. The cost for providing the requested documentation is the employee's responsibility.

- If The Standard asks a provider to provide documentation to complete a claim packet, the provider must provide that documentation within 45 days of The Standard's request. Otherwise, the claim may be denied.

BLTD/SLTD payments

- The Standard may pay BLTD and/or SLTD benefits within 60 days after The Standard receives satisfactory proof of loss.
- BLTD and/or SLTD benefits will be paid to an employee at the end of each month he qualifies for benefits. The payment should be received by the first of the month for the previous month.
- Any BLTD benefits remaining unpaid will be paid to the employee's estate. Any SLTD benefits remaining unpaid will be paid to the person(s) eligible to receive the survivor benefit that is defined in the SLTD policy. In case there are no eligible survivors as defined in the SLTD policy, survivor benefits would not be paid, and any SLTD benefits remaining unpaid would then be paid to the employee's estate.

No assignment

The rights and benefits of the SLTD and BLTD plans cannot be assigned (paid to a third party).

Advise of adjustments and potential overpayments

- Remind any employee who is applying for BLTD and SLTD benefits that these benefits are REDUCED by other forms of deductible income, or offsets, as outlined in the IBG.
- These offsets are applied against BLTD and SLTD benefits, according to an individual's eligibility to receive them, regardless of whether he actually does receive them.
- Eligibility for any benefits (Social Security, PEBA retirement benefits disability, workers' compensation, sick leave, return-to-work earnings, etc.) should be reported to The Standard immediately as they may be considered offsets.

Waiver of premiums

The SLTD premium waiver begins the first of the month after the end of the benefit waiting period, and premiums should continue until then. The Standard will contact PEBA, the benefits administrator and the employee when the disability claim is approved. The waiver ends when the employee returns to work. At that time, notify The Standard and complete the [SLTD Premium Waiver Form](#).

The Standard prepays FICA and Medicare

BLTD and SLTD benefits are subject to taxes, including FICA and Medicare.

- The employee share of these taxes is deducted before the benefit payments are issued.
- Standard prepays the employer share and bills the employer quarterly for reimbursement of these amounts. You will receive a letter itemizing the charges. Follow the instructions outlined in the letter. If you receive such a letter and have any questions, please call Jeri Elsasser at The Standard at 971.321.5387.

When the benefits administrator should call The Standard

Notify The Standard when you become aware of any of the following events concerning an employee receiving SLTD and/or BLTD benefits:

- Employee receives deductible income/offsets (PEBA retirement benefits disability or retirement benefits, Social Security disability or retirement benefits, workers' compensation benefits, sick leave or shared leave, etc.);
- Employee returns to work (in any capacity);
- Employee needs help or assistance in returning to work;
- Employee dies; or
- Employee is terminated.

MoneyPlus

- If on leave due to disability, the employee can continue his MoneyPlus accounts as explained on Page 59 under Unpaid leave or reduction in hours.
- If the employee is eligible for disability retirement through PEBA, his options are explained in the Retiree subscribers chapter of this manual.



Claims and appeals

Claims and appeals

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Many of the claims and appeals procedures are outlined in the [Insurance Benefits Guide](#) (IBG). Refer to the appropriate benefit sections of the IBG for general claims and appeals information and procedures.

This section highlights specifics related to filing claims and appeals that are not included in the IBG and that you might need to know as a benefits administrator.

State Health Plan claims

Network providers file claims for subscribers. However, to receive benefits when a hospital or doctor does not file, subscribers can file a claim manually, as outlined in the *Insurance Benefits Guide*.

Tips for filing claims

The name on the claim form (if filed manually) should match the name with PEBA.

Allow about three weeks to receive an Explanation of Benefits (EOB) before calling BlueCross or PEBA for assistance.

Claims should be filed as soon as possible, but **MUST** be filed no later than the end of the calendar year following the year in which expenses are incurred. Claims filed after that time will be denied.

The claim form cannot be used to make an address change; subscribers should notify their benefits office immediately of any address change. Subscribers can also change their addresses online using MyBenefits.

State Health Plan claims for services outside the U.S.

Claims outside the U.S. are filed for subscribers through the BlueCross BlueShield Global® Core provider network, previously known as the BlueCard Worldwide Programs. However, to receive benefits when a hospital or doctor does not file, subscribers can file the BCBS Global Core International Claim Form manually. The BCBS Global

International Claim Form is on the PEBA website at www.peba.sc.gov.

Coordination of benefits

State Health Plan benefits for health and prescription drug coverage are coordinated with other coverage that a subscriber, his covered spouse or his covered children may have. Refer to the IBG for the general rules about how to determine which plan is considered primary or secondary.

Prescription drug benefit

If the State Health Plan is the secondary payer for prescription drug benefits when coordination of benefits applies, the covered person should present the primary insurance card first.

The person would then file a manual claim for any benefits due as the secondary payer. The prescription drug program's manual claim form is on the PEBA website at www.peba.sc.gov.

A person with a MoneyPlus debit card is advised not to use the card at the pharmacy when the State Health Plan is the secondary payer, because the manual claim must be filed to determine the amount of unreimbursed expense before filing a Medical Spending Account claim.

Claims for an active subscriber with Medicare

(Medicare is the secondary payer under the active group, unless the employee, spouse or child is enrolled in Medicare solely due to end-stage renal disease.)

When an active employee, his spouse or his child(ren) is enrolled in Medicare, claims are filed with BlueCross first. Once the employee receives the Explanation of Benefits (EOB), he should send an itemized bill and a copy of the EOB to Medicare to be processed for secondary benefits. If an employee is enrolled in Medicare solely due to end-stage renal disease, contact Medicare for additional information. After 30 months, Medicare becomes

the primary payer for a subscriber with end-stage renal disease.

Claims for a retiree subscriber with Medicare

Medicare is the primary payer for a retiree who is eligible for Medicare. The State Health Plan (including the Medicare Supplemental Plan) coordinates claims payment as though the subscriber is enrolled in Medicare Part A and B, regardless of whether the subscriber is actually enrolled. Prior to Medicare eligibility, the Plan is the primary payer.

A retiree, who is not eligible for Medicare by his own employment record, but who may become eligible on a spouse's employment record, must enroll for Medicare when the spouse enrolls. If either refuses Medicare coverage, the Plan still coordinates claims payment as if they have both Part A and Part B benefits. If the Medicare-eligible subscriber is not covered by Part A and Part B, he will be required to pay the portion of his health care costs that Part A and Part B would have covered.

Accident questionnaires

For accident-related claims, BlueCross may need information about the event. BlueCross gathers this information through an accident questionnaire. Gathering this information is typically related to subrogation, when more than one party is involved in the accident. Subrogation is explained under Terms to Know in the [Insurance Benefits Guide](#).

- Questionnaires are sent to subscribers when there is a claim filed for treatment of an injury or diagnosis that has been established by BlueCross' staff of physicians as likely to be an accident or work-related.
- Questionnaires are generated once per week. Subscribers can receive multiple questionnaires related to the same event, due to any of the following:
 - BlueCross may not have received a response to the first questionnaire before a second one is sent.

Additional questionnaires will be sent to the subscriber each week until BlueCross receives a completed one.

- Subscribers may also receive more than one questionnaire if more than one covered person in the family receives treatment related to the same accident. A separate questionnaire is sent for each covered individual being treated for injuries related to the accident. The name of the patient is included at the top of the questionnaire.
- Once BlueCross receives a questionnaire response, it is valid for six months. If claims meeting the established accident-related criteria are reported more than six months after the original accident date, the subscriber will receive another questionnaire.
 - This six-month cycle helps BlueCross identify any subsequent accidents that may have occurred.
 - If claims reported more than six months after the original accident are related to that event, the subscriber should simply check the update space and return the questionnaire to BlueCross. This will update the subscriber's file for another six months.

Mental health and substance use claims

Office visit services for psychological or neuropsychological testing and applied behavior analysis and all hospital inpatient, partial and intensive outpatient program admissions must be preauthorized by CBA.

In-network claims

The provider files claims when the subscriber, his covered spouse or his covered children use a

provider that participates in the mental health and substance use provider network.

Out-of-network claims

The subscriber must complete and submit a claim form for out-of-network services. The claim form is the same for State Health Plan medical claims and mental health and substance use claims. The subscriber can file a claim manually as outlined in the IBG.

Dental Plus and Basic Dental claims

Most dental offices can file claims directly with BlueCross. However, to receive benefits when a dentist does not file directly, subscribers can file a claim manually as outlined in the *Insurance Benefits Guide*. The [dental claim](#) form is on the PEBA website.

Tips for filing claims

- The name on the [dental claim](#) form (if filed manually) should match the name on the NOE with PEBA.
- A Pretreatment Estimate from BlueCross must be returned with the claim after the services are rendered. These estimates are valid for one year.
- Allow about three weeks to receive an EOB before calling BlueCross or PEBA for assistance.
- Claims should be filed as soon as possible, but MUST be filed no later than 24 months following the date charges were incurred. Claims filed after that time will be denied.
- The [dental claim](#) form cannot be used to make an address change; subscribers should notify their benefits office immediately of any address change or update their address online through MyBenefits.

State Vision Plan claims

In-network claims

There are no claims to file when the subscriber uses a provider that participates in EyeMed's provider network. EyeMed no longer requires pre-authorization for medically necessary contact lenses. The provider is responsible for determining adherence to the criteria and submits a medically necessary contact lens claim form to EyeMed directly.

Out-of-network claims

The subscriber must complete and submit an [Out of Network Vision Services Claim Form](#) to be reimbursed for eligible expenses. This form is on the PEBA website at www.peba.sc.gov.

- EyeMed will accept only itemized, paid receipts that list the services and the amount charged for each service. Handwritten receipts must be on the provider's letterhead.
- Attach itemized receipts to the completed claim form and mail to EyeMed's Out-of-Network Claims department at the address on the claim form's instructions page.

Denials and appeals

Because the Vision Plan is fully insured, subscribers cannot appeal EyeMed determinations to PEBA.

If a claims question cannot be resolved by EyeMed's Customer Care Center, the subscriber may write to:

EyeMed Vision Care
Attn: Quality Assurance Department
4000 Luxottica Place
Mason, OH 45040

Information may also be faxed to 513.492.3259. EyeMed will work with the subscriber to resolve the issue within 30 days. If the subscriber is dissatisfied with EyeMed's decision, the subscriber may appeal to an EyeMed appeals subcommittee. All appeals

are resolved by EyeMed within 30 days of the date the subcommittee receives it.

Life insurance claims

Policy Number 200879

Complete the [Active Termination Form](#) in EBS, canceling life insurance coverage.

Completing the claim form

Log in to [MetLink](#) to complete the *Life Insurance Claim* form. This form is also on the PEBA website at www.peba.sc.gov.

1. Complete parts 1, 2 and 4 if the employee dies.
 - In Part 1, the employer/policyholder name is South Carolina PEBA; the group customer number is 200879.
 - For Part 2, attach a copy of the subscriber's NOE, SOE or SOC showing his coverage; for date employer's unit entered group insurance plan, list 01/14/18 or the date your employer began participating with PEBA, if later than January 1, 2018; for address and telephone number of beneficiary, provide whatever information you have and a copy of the form naming the beneficiary; and for amount of insurance, list the amount of Basic Life and Optional Life separately.
- Complete parts 1, 3 and 4 if the dependent dies.
 - In Part 1, the employer/policyholder name is South Carolina PEBA; the group customer number is 200879.
 - For Part 2, attach a copy of the subscriber's NOE, SOE or SOC showing his coverage; for marital status of employee and duration of final illness, list the information if

you have it (the form can be processed without it).

2. After the *Life Insurance Claim* form is complete, send it, along with coverage verification and beneficiary information, to MetLife.
 - Fax the information to 570.558.8645; or
 - Mail the information to MetLife
Group Life Claims
P.O. Box 6100
Scranton, PA 18505-6100
3. After MetLife receives the completed claimant statement and certified death certificate, the claim will either be approved, and payment will be made to the beneficiary, or the claim will be denied, and MetLife will send a notification of denial to the beneficiary.

Claims that are completed and submitted properly are typically processed within 10 business days, unless there are extenuating circumstances surrounding the death.

Allow at least 10 business days before checking the claim status if it is an uncomplicated claim. More complicated claims — accidents and homicides — may require an in-depth investigation. MetLife may also need to request additional medical information. Payment will be determined after the investigation is complete. If a beneficiary has a question about the status of a life insurance claim, he may call MetLife at 800.638.6420, then press 2.

Retirees

If the claim is for a deceased retiree, the beneficiary should call MetLife at 888.507.3767. The necessary claim form will be sent to the correct party for completion.

Claims payments

MetLife will pay life insurance benefits to the beneficiary or beneficiaries as indicated on the NOE, in EBS or on [Metlink](#).

Exceptions:

- Estate of the insured: Benefits will be paid to the administrator or executor of the deceased's estate.
- A minor: Benefits will be paid to the court-appointed guardian for the minor and minor's estate.
- An incompetent beneficiary: Benefits will be paid to the guardian or other appointed representative for the beneficiary.
- In these situations, a court certificate showing the appointment must be submitted. Do not delay submitting proof of death. Send it in, noting the court certificate of appointment is pending.
- When the claim is approved, MetLife will send a payment notice to the beneficiary.
- You may go to Life Benefits Extra to check the status of a claim.

Assignment

MetLife is not responsible for the validity or tax consequences of any payment to a third party (called *assignment*). An assignment is the irrevocable, legal transfer of some or all of the *interest* (amount payable in the future) under a policy to a third party. The individual with the interest (e.g., the insured) makes the irrevocable assignment. The insured can assign certain rights, such as (but not limited to):

- The right to convert group coverage to individual coverage.
- The right to designate or change a beneficiary.
- The right to accelerate death benefits, if applicable.
- The right to increase coverage, as applicable.

- No assignment will be binding on MetLife until MetLife receives a completed Absolute Assignment to Trust form, records and acknowledges it. This form is available from MetLife by calling 800.638.9696.
- Assignments for collateral are not permitted (such as for a loan).
- PEBA will maintain a copy of records of death claim payments.

Accidental death benefit

Completing and filing a [Statement of claim for Accidental Death and Dismemberment benefits](#) in cases of accidental death can be done using [MetLink](#). See the Life Insurance chapter of the [Insurance Benefits Guide](#) for descriptions of additional accidental death benefits.

Suicide

Suicide is a covered life claim; however, double-indemnity benefits are not payable. No Optional Life or Dependent Life-Spouse benefits are payable if death results from suicide, whether sane or insane, within two years of the effective date. If death occurs within two years of the effective date of an increase, the death benefit payable is limited to the amount of coverage prior to the increase.

Other benefits

Dismemberment benefits

If a claim is for dismemberment or loss of vision, the benefits administrator, employee and his physician must complete the [Notice of Accidental Dismemberment and Loss of Sight Claim](#) form and submit it to MetLife. Dismemberment benefits are not available to retirees or dependent children.

Accelerated benefits option (Living benefit option)

When a physician diagnoses an employee or his covered dependents as terminally ill with a life expectancy of no more than 12 months, the employee may request that MetLife pay up to 80 percent of his Optional Life or Dependent Life benefit prior to death, up to \$400,000. The benefits

administrator, employee and his physician must complete the Notice of Claim for Accelerated Benefit form and submit it to MetLife.

If terminating employment, refer to the Transfers and Terminations chapter for additional information and procedures.

Dependent Life

Policy Number 200879

Follow the claims procedures explained on Page 130.

- File a claim using [MetLink](#). If the spouse or child was the last eligible covered family member, and the level of coverage is affected by the spouse's or child's death, the employee has 31 days to complete the coverage change.
- If coverage is not affected, to delete the spouse's or child's name the employee must still complete, sign and date an NOE.
- Dependent Life pays double the amount for accidental death of a covered spouse, but not a covered child.

Dependent Life Accidental Death and Dismemberment

The procedures for filing accidental death and dismemberment claims for covered spouses are the same as for employees.

Denials and appeals (Optional Life and Dependent Life)

If the claim is denied, MetLife will notify the claimant in writing. The notice of denial states:

- The specific reason(s) for the denial;
- A reference to the plan provisions on which the denial is based;
- An explanation of the review procedure.

The claimant may request an appeal in writing.

- Eligibility appeals should be sent to PEBA. For more information regarding the PEBA appeals process, please see Page 136.
- All other appeals should be sent to MetLife.

Long term disability claims

Basic Long Term Disability

(BLTD Policy #627284-B)

Supplemental Long Term Disability

(Policy #621144-B)

The [LTD Benefits Claim Form packet](#) for both BLTD and SLTD is 16 pages; the latest version is always available on the PEBA website, www.peba.sc.gov. It should be completed as soon as the employee is absent from work for more than 31 days or when modified duties have exceeded 31 days. Employees may work part-time or have modified duties and still be eligible for benefits. Detailed instructions are printed on the first two pages of the packet. If the employee is not able to apply for benefits, the benefits administrator may apply on behalf of the employee.

- Give employees applying for LTD benefits the latest LTD Certificate(s) of Coverage(s). Both certificates of coverage, for BLTD and SLTD, are available on the PEBA website.
- The employee completes the Employee's Statement (in the packet) and signs and dates it where indicated.
- The employee signs and dates the next section, Authorization to Obtain and Release Information (in the form packet).
- The employee should also sign and date the next section, Authorization to Obtain Psychotherapy Notes, if applicable (in the packet).
- The employee should forward the Employee's Statement and both authorizations to The Standard at the address on the form.

- The employee completes only Part A of the Attending Physician's Statement (in the packet) and forwards it to his physician, who should complete Part B. The physician should forward the completed Attending Physician's Statement directly to The Standard at the address on the form.
- The employee should complete Section 1 of the Employer's Statement (in the packet) and forward it to his benefits administrator. The benefits administrator should complete this section and forward it directly to The Standard at the address on the form.

Documentation

Satisfactory written proof that the employee is disabled and entitled to BLTD and/or SLTD benefits must be provided. The packet must be completed by the appropriate parties in its entirety.

Time limits for filing and substantiating claims:

- An employee should submit a completed packet to The Standard as soon as possible, but within 90 days after the end of the benefit waiting period (90 or 180 days, based on the chosen benefit waiting period). The Standard will review the *completed claim* upon receipt.
- In situations where the employee is unable to obtain the information to submit a completed claim to The Standard within the timeframe above, The Standard will accept completed claims up to one year after the 90-day period following the respective benefit waiting period (see above).
- If a completed claim is not filed within this time period, the employee's claim will be denied.
- These time limits do not apply while the employee lacks legal capacity. In this situation, the benefits administrator should contact The Standard for additional information and instructions.

Investigation of claim

Once The Standard receives a completed claim packet, The Standard will review the claim and gather any additional information necessary to make a determination on the claim.

- The Standard continues to manage the employee's claim and may investigate the claim at any time for the duration of the claim.
- At The Standard's expense, The Standard may have the employee examined at any time by specialists of The Standard's choice. The Standard may deny or suspend benefits if an employee fails to attend an examination or cooperate with the specialist.

If The Standard approves the employee for SLTD benefits, The Standard will notify PEBA, the employee and the benefits administrator of the approval.

- The employee's premiums are waived while SLTD benefits are payable.
- PEBA will process the waiver of premiums and generate a letter to the benefits administrator, requesting the benefits administrator notify PEBA immediately if the employee ever returns to work.

Denials and appeals

If the claim is denied, the decision is made within a reasonable period (in most cases, no more than 105 days) and communicated afterward. The notice of denial states:

- The specific reason(s) for the denial.
- A reference to the plan provisions on which the denial is based.
- A description of additional information or material that may reverse the denial decision and why it is necessary.

How to request an appeal of a long term disability claim

- The claimant can write to Standard Insurance Company, P.O. Box 2800, Portland, OR 97208, to request a review.
- The request must be made to The Standard within 180 days of receipt of the denial letter.
- The claimant should include any additional documentation to be considered.
- The claimant will receive notification of The Standard's final decision within 90 days of the request, or within 120 days if special circumstances require an extension.
- If The Standard reviews the claim and upholds the denial, the claimant will receive correspondence from the Administrative Review Unit at The Standard, including instructions for appealing the decision.

If The Standard upholds its decision on a claim—BLTD only:

- An appeal may be filed with PEBA within 90 days of the notice of denial.
- If the denial is upheld by PEBA, the subscriber has 30 days from receipt of the denial letter from PEBA to seek judicial review as provided by S.C. Code Ann. § § 1-11-710 and 1-23-380.

Please note: Because Supplemental Long Term Disability is fully insured by The Standard, SLTD decisions may not be appealed to PEBA.

Refer to the Disability Subscribers section of this manual for additional information.

MoneyPlus claims and reimbursement

Medical Spending Account and Dependent Care Spending Account reimbursements

The employee files claims for reimbursement directly with ASIFlex, administrator for the MoneyPlus program.

During the plan year, the minimum check reimbursement amount is \$25 unless a smaller reimbursement amount would clear the account balance. At the end of the run-out period, the minimum reimbursement amount is waived to allow for maximum reimbursement.

ASIFlex offers several easy ways to submit claims for reimbursement. Employees do not have to choose only one option; they can use multiple options throughout the year.

- **ASIFlex mobile app** Download the app and log in to his account. Then, just snap a picture of the itemized receipt and submit a claim via the app.
- **ASIFlex Online** Sign in to his online account to submit a claim.
- **Toll-free fax or mail** Download and complete a claim form. Then, submit it with an itemized receipt. Employees should keep a copy for their records.

If approved, reimbursement will be made within three business days following receipt of complete claim. Employees can log in to their ASIFlex account to sign up for direct deposit, as well as email and text alerts. Employees can also opt to receive a mailed check.

Contact ASIFlex's Customer Service at 833.SCM.PLUS (833.726.7587) if you have any questions.

Special notes on Medical Spending Account reimbursements

Only the eligible expenses an employee must pay may be claimed. Any medical expenses that are already covered by health, dental or vision insurance are not reimbursable.

MSA reimbursements are issued for the full amount of the claim, regardless of the employee's account balance, up to the unused portion of the elected annual deduction.

If not continuing an MSA after termination through COBRA, the employee has through the run-out period to submit claims incurred during his period of coverage while he was an employee.

ASIFlex debit card reimbursements

The ASIFlex debit card may be used at:

- Medical service providers, such as physician and dental offices, hospitals, medical labs;
- Prescription drug mail-order websites, such as Express Scripts Pharmacy, the State Health Plan's mail-order prescription drug service; and
- Pharmacies and any other stores that use Inventory Information Approval Systems (IIAS) (they have coded their prescriptions and eligible over-the-counter items so they can be identified electronically by the debit card and other Medical Spending Account card programs). Only the items that are coded into the IIAS may be purchased with the card. *Example:* If you go to Walgreens (this chain uses IIAS) and buy a prescription, contact lens solution and a magazine, the charge for the magazine will not go through on the card. You would have to pay for that item separately. Note that the debit card cannot be used to pay for over-the-counter drugs and medicine.

Persons with an ASIFlex debit card should not use the card at a pharmacy if they have other coverage, because claims for both primary and secondary plans must be filed to determine the amount of

unreimbursed expense before filing a Medical Spending Account reimbursement.

Documentation

ASIFlex will receive claims information from other third-party vendors to auto-adjudicate as many card transactions as possible. Use of the card, however, is not paperless. Employees may be required to submit documentation to substantiate claims.

Requests for documentation are emailed and posted to online secure message center; participant has 47 days to respond.

- An initial notice is sent approximately five days after ASIFlex receives notice of transaction.
- A reminder notice is sent 21 days after initial notice.
- A deactivation notice is sent 21 days after reminder notice.
- Future claim submissions offset by outstanding amount.

Card transactions that remain unsubstantiated by March 31 after the end of the plan year are taxable as income, and ASIFlex will send a report to employers listing all unsubstantiated card transactions. Refer to the Accounting, Billing and Reports section of this manual for additional information.

Special notes on Dependent Care Spending Account reimbursements

- The dependent care provider may sign the [MoneyPlus claim form](#) where indicated in lieu of a receipt for the DCSA.
- There must be sufficient funds in the account balance to reimburse DCSA expenses. Payroll deduction data from the employer is submitted to ASIFlex after payroll processing. If an employee submits a dependent care reimbursement request before ASIFlex receives and posts the payroll data, the request is suspended and then paid within three working days after the payroll data arrives. A suspended

request results also when an employee incurs dependent care expenses for more than the account balance. Payment for the balance is issued. Additional reimbursements are issued as the payroll data arrives and the funds become available.

Special notes on Health Savings Account reimbursements

- There must be sufficient funds in the account balance to reimburse eligible HSA expenses.
- MoneyPlus HSA contributions are transferred from the employer to ASIFlex. ASIFlex processes the payrolls and transfers the funds to Central Bank, the custodian for the MoneyPlus HSA accounts. Central Bank then posts the funds to each account.
- The standard processing timeline for HSA contributions to be available in participants' accounts is two business days from the date all payroll information is received.
- The participant is responsible for reimbursing himself from his HSA by using his HSA debit card at the time of service or transferring funds from his HSA to his checking account online. He can also use the debit card at an ATM to reimburse himself for out-of-pocket expenses, but fees may apply. Any withdrawals must be for health care expenses that qualify under IRS guidelines. If they do not qualify, they may be subject to taxes and penalties.
- The participant is responsible for ensuring that he reimburses himself *only for eligible expenses*.
- The participant is responsible for retaining documentation and providing it to the IRS if requested.

Administrative or eligibility appeals

If an employee, retiree, survivor, spouse, former spouse or child(ren) is unable to enroll, disenroll or change their coverage, the subscriber has the right to a review.

Examples include, but are not limited to:

- Eligibility for incapacitated child coverage;
- Enrollment in MoneyPlus;
- A coverage change request outside of an open enrollment period;
- A coverage change request more than 31 days after a special eligibility situation occurs;
- Eligibility for nonfunded, partially-funded or funded retiree coverage;
- Extension of COBRA coverage; and
- Removal of the tobacco-use premium.

Retirees, survivors and COBRA subscribers of state agencies, public school districts or higher education institutions can submit requests directly to PEBA, which serves as their benefits administrator.

Retirees, survivors or COBRA subscribers of optional employers can submit requests through the benefits office of their former employer, which serves as their benefits administrator.

Employees should submit a request for review through their benefits administrator. Benefits administrators must use a [Request for Review form](#). The form is on PEBA's website, www.peba.sc.gov.

A request for review describes the subscriber's issue, explains the surrounding circumstances and includes any necessary documentation. The benefits administrator must submit the request and all supporting documentation, including a completed NOE, regardless of whether the benefits administrator supports the subscriber's request. The completion of an NOE does not guarantee PEBA will approve the request.

If a mistake was made by the benefits office, such as misplacing or failing to submit documentation in a timely manner, the benefits administrator should describe the error and mark the change reason as “BA clerical error or delay.” Subscriber negligence is not considered a BA clerical error or delay.

If no mistake was made by the benefits office, the benefits administrator should describe the subscriber’s issue and circumstances in the Change requested section and mark the change reason as Subscriber request.

The benefits administrator will need to include:

- The group name, subscriber’s name, BIN and date of the request;
- Complete details;
- An additional explanation sheet, if necessary;
- All relevant documentation; and
- The benefit administrator’s signature.

If making a change to coverage, the benefits administrator will need to include an original NOE, completed and signed by the subscriber and the benefits administrator. The NOE must correct the error addressed on the [Request for Review form](#). The request for review cannot be completed without an NOE showing the requested change.

A [Request for Review form](#) must be attached to an NOE whenever an effective date correction is more than 90 days retroactive.

A [Request for Review form](#) is not required for retroactive termination of a subscriber’s file. If the retroactive termination exceeds 31 days, the employer is responsible for paying any premiums beyond the 31-day period, back to the date of termination.

If the request is approved due to a BA clerical error or delay, then the approval is effective retroactively, up to one year back to the actual effective date. Any premiums due must be paid. Changes cannot be made prospectively or for the date the request is made.

Example: A new employee was hired on March 1, 2018, but due to the benefits administrator’s delay, the NOE is not submitted to PEBA until July 1, 2019. PEBA receives the [Request for Review form](#) and NOE to add the employee effective July 1, 2019. PEBA cannot add the employee effective July 1, 2019. The employee will be added effective July 1, 2018 (one year retroactive from PEBA’s receipt of the request, as the request was received more than one year after the hire date of March 1, 2018). Premiums are due from July 1, 2018, forward.

If the request is approved for any other reason, PEBA will process the NOE and notify the benefits administrator of any other needed documentation.

If the request is denied, PEBA will send the benefits administrator a denied [Request for Review](#) form. The benefits administrator must send a copy of the denied [Request for Review form](#) to the subscriber, notifying him that he has 90 days to appeal to PEBA.

If the subscriber disagrees with PEBA’s decision, the subscriber may appeal by writing to PEBA within 90 days of the denied request. The subscriber should explain why he is appealing, attach any additional information and supporting documents and include a copy of the denied [Request for Review form](#). If the request for review was denied because of lack of documentation, the subscriber should include the previously missing documentation.

A benefits administrator, employer or healthcare provider may not appeal to PEBA on the subscriber’s behalf. Only the subscriber, his authorized representative or a licensed attorney admitted to practice in South Carolina may initiate an appeal through PEBA. A benefits administrator, employer or healthcare provider may not be an authorized representative.

In most cases, the appeal should be sent to IAD@peba.sc.gov or:

S.C. PEBA
Attn: Insurance Appeals Division
202 Arbor Lake Drive
Columbia, SC 29223

If the appeal is urgent and relates to a pregnancy, newborn child or the preauthorization of a life-saving treatment or drug, the subscriber may send the appeal to urgentappeals@peba.sc.gov.

PEBA will review the request and make every effort to process the subscriber's appeal within 180 days of the date all the appeal information is received. However, this time may be extended if additional material is requested or if the subscriber asks for an extension. PEBA will send the subscriber periodic updates on the status of the review. Once PEBA's review of the appeal is complete, the subscriber will receive a written determination in the mail.

If the appeal is approved, PEBA will process the NOE and notify the subscriber and his benefits administrator of any other needed documentation.

If the appeal is denied, PEBA will send the subscriber a detailed decision letter explaining the reason(s) for denial. The subscriber will then have 30 days to seek judicial review at the Administrative Law Court, as provided by Section 1-11-710 and 1-23-380 of the S.C. Code of Laws, as amended.

Appeals related to claims or authorization of benefits

If an employee, retiree, survivor, spouse, former spouse or child is seeking authorization of benefits or reimbursement for a claim, the subscriber has the right to a review.

Vision, life insurance and Supplemental Long Term Disability benefits are fully insured products, and are not to be appealed to PEBA. Page 136 describes the appeals process for these fully insured products.

All other coverage issues related to claims or the authorization of benefits are appealed first to the applicable third-party claims administrator and then to PEBA. Examples include, but are not limited to:

- Preauthorization of medical, behavioral health, or dental services, and treatments or devices;

- Prior authorization of prescription medication;
- Reimbursement of MoneyPlus claims;
- Reimbursement of claims for medical, behavioral health or dental services, and treatments, or devices; and
- Payment for Basic Long Term Disability claims.

The subscriber must first request authorization of benefits or payment of a claim from the appropriate third-party claims administrator. If the third-party claims administrator denies the request, then the subscriber can appeal to the third-party claims administrator (within three days for radiology preauthorization appeals, 31 days for MoneyPlus appeals and within six months for other appeals). If the third-party claims administrator denies the appeal, the subscriber can appeal to PEBA within 90 days.

There is one exception. Express Scripts, the pharmacy benefits manager, may conduct one to three reviews, depending on the circumstances of the appeal. Once the appeals process at Express Scripts is completed, Express Scripts will send a decision letter to the subscriber. If denied, the denial letter will describe the subscriber's appeal rights to PEBA. The subscriber will still have 90 days to appeal to PEBA.

Third-party claims processors

- **BlueCross BlueShield of South Carolina** (health insurance claims)
StateSC.SouthCarolinaBlues.com
803.736.1576 or 800.868.2520
- **Medi-Call** (medical preauthorization)
803.699.3337 or 800.925.9724
- **Companion Benefit Alternatives** (behavioral health benefits preauthorization)
www.CompanionBenefitAlternatives.com
803.736.1576 or 800.868.2520
- **National Imaging Associates** (radiology preauthorization)
www.RadMD.com

866.500.7664

- **Express Scripts** (prescription medication)
Express Scripts
Attn: Benefit Coverage Review Department
P.O. Box 66587
St. Louis, MO 63166-6587
- **BlueCross BlueShield of South Carolina** (dental claims)
BlueCross BlueShield of South Carolina
Attn: State Dental Appeals
AX-B15
P.O. Box 100300
Columbia, SC 29202-3300
- **Standard Insurance Company** (Basic Long Term Disability)
Standard Insurance Company
P.O. Box 2800
Portland, OR 97208
- **ASIFlex** (MoneyPlus claims)
ASIFlex Appeals
Attn: S.C. MoneyPlus
P.O. Box 6044
Columbia, MO 65205-6044

Once the subscriber has received the denial letter from the third-party claims administrator with the 90-day appeal language, the subscriber can appeal to PEBA.

A benefits administrator, employer or healthcare provider may not appeal to PEBA on the subscriber's behalf. Only the subscriber, his authorized representative or a licensed attorney admitted to practice in South Carolina may initiate an appeal through PEBA. A benefits administrator, employer or healthcare provider may not be an authorized representative.

In most cases, the appeal should be sent to IAD@peba.sc.gov or:

S.C. PEBA
Attn: Insurance Appeals Division
202 Arbor Lake Drive
Columbia, SC 29223

If the appeal is urgent and relates to a pregnancy, newborn child or the preauthorization of a life-saving treatment or drug, the subscriber may send the appeal to urgentappeals@peba.sc.gov.

PEBA will review the request and make every effort to process the subscriber's appeal within 180 days of the date all the appeal information is received. However, this time may be extended if additional material is requested or if the subscriber asks for an extension. PEBA will send the subscriber periodic updates on the status of the review. Once PEBA's review of the appeal is complete, the subscriber will receive a written determination in the mail.

If the appeal is denied, PEBA will send the subscriber a detailed decision letter explaining the reason(s) for denial. The subscriber will then have 30 days to seek judicial review at the Administrative Law Court, as provided by Section 1-11-710 and 1-23-380 of the SC Code of Laws, as amended.



**Accounting, billing
and reports**

Accounting, billing and reports

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General information

This section gives instructions on how to use the information found on the monthly billing statement and in various reports. This is only a guide; it will not cover every situation. If you have any questions after reading these instructions, call the PEBA Insurance Finance account representative for your group at 803.734.1696 or at 888.260.9430.

Accounting definitions

Payroll Center: The office or area of a participating employer that processes the payrolls of its employees, including premiums for insurance coverage.

Retroactivity (RETRO): A charge or credit of premiums that occurred because a coverage election was processed with an effective date prior to the current billing statement month.

General accounting rules

Collecting premiums for mid-month changes

Changes in status

- For changes in status effective *on or before the 15th of the month*, collect premiums for that entire month.
- For changes in status effective *after the 15th of the month*, start collecting premiums the first of the following month.

Death of employee/subscriber

- If terminating coverage due to death of an employee or other subscriber *on or before the 15th of the month*, do not collect premiums for that month.
- An exception: If the employee or other subscriber dies *on the 15th of the month*, coverage will be terminated on the 16th of the month. (This is to make sure all claims for the month are paid.) Collect premiums for the entire month.

- If terminating coverage due to death of an employee or other subscriber *after the 15th of the month*, collect premiums for that entire month.

Unpaid leave rules

(Applies to all employers)

For more information and policies regarding unpaid leave, refer to the Active subscriber's chapter under unpaid leave or reduction in hours.

- Participating employers are responsible for collecting all premiums and submitting them to PEBA Insurance Finance. In relation to this responsibility, an employee authorizes his employer to collect his portion of the premiums for the coverage selected.
- The employer will be billed and is required to pay all outstanding premiums to PEBA Insurance Finance.
- In an unpaid leave situation, the employer should be consistent and fair with notification and time allowances on premium payments owed by the employee.
- If the employee does not pay the premiums, the employer can terminate the coverage for non-payment of premiums, but only up to 31 days retroactive.
- See Submitting premiums for employees on unpaid leave for more information.

Issuing credits

(Applies to all employers, except CG agencies)

PEBA Insurance Finance does not issue individual refunds. Instead, a credit is applied to the billing statement through processing an NOE, and the employer then refunds the subscriber.

- When a refund of tax-deferred premiums is issued to an employee, the employee's taxable salary should be adjusted for his W-2 records. It is not PEBA Insurance Finance's responsibility to make sure this adjustment is made.

Active accounting system

Billing statement

You may view your bill through the Employee Benefits Services (EBS) website (<https://ebs.eip.sc.gov>). Groups without EBS access will receive paper copies in the mail.

Active group billing statement (applies to all groups)

Frequency: Monthly

On or before the first of each month, PEBA Insurance Finance produces a billing statement. This billing statement enables each group to maintain the accounting records of each employee. If the group verifies the information printed on the billing statement and communicates with PEBA Insurance Finance whenever there are questions about the data, the financial process for employees' benefits should work smoothly.

This section of the manual includes descriptions of the billing system for the following insurance programs and plans:

- State Health Plan*;
- GEA TRICARE Supplement Plan;
- Dental Plus Plan;
- Basic Dental;
- State Vision Plan;
- Basic Life;
- Optional Life;
- Dependent Life-Spouse;
- Dependent Life-Child(ren);
- Basic Long Term Disability; and
- Supplemental Long Term Disability.

**The tobacco-use premium will appear separately from the health premium on the billing statement.*

Online Bill Pay

Employers who are not on SCEIS have the option to remit insurance premiums online. Processing your payment online is an easy and convenient way to pay your monthly insurance premiums.

To use this feature, you will need to do these things:

- Log in to EBS to use Online Bill Pay.
- Complete a new EBS Designated Employee Confidentiality Agreement form.
- Verify your email address in the lower right corner on the EBS homepage before submitting payment. If you need to make a correction, click the Update My Email Address link.

After you complete these steps, you will be able to:

- Schedule a payment;
- View the status of your account;
- View bill and payment history for previous 12 months; and
- View billing statements for previous 12 months.

Please note, the minimum amount you may pay is your current balance.

Group address page

This page contains the group identification number, along with the name and complete address of the group. This page also lists the name of the person PEBA Insurance Finance will contact if there are any questions. Your group's billing contact person should be the individual responsible for remitting payment for insurance premiums. If there is a change in the contact person or address, the Authorizing Agent for your group should update this information through EBS. In the middle of the page is the section that lists the account representative for each group and PEBA Insurance Finance's return address. At the bottom of the page, there is a key/legend that refers to the Coverage Processing section of the billing statement.

Account summary pages

These two pages summarize the prior month's activity, ending with the net premium outstanding from the prior month and the billing for the current month. The first page lists information for the employer share, health, dental, Optional Life and Dependent Life-Spouse. The second page pertains

to Dependent Life-Child, SLTD, vision and the tobacco-use premium.

Below is a description of each section on these pages.

- Beginning Balance lists the Total Net Balance due from the prior month's billing statement.
- Payment Transactions lists all payments received since the completion of the prior month's billing statement, including SCEIS payroll deductions and returned payments.
- Accounting Transactions lists all refunds, canceled refunds and accounting adjustments processed since the prior month's billing statement. There are two types of accounting adjustments: one type is for a subscriber and the other type is an adjustment to the group account. *For example*, a subscriber adjustment is processed to correct the effective date of a coverage change. A group account adjustment is processed to correct a payment posted incorrectly. If an adjustment is processed for a subscriber, the BIN will be listed on the Account Summary page and an Adjustment form will be mailed to the group. This form will show the amount and explain why the subscriber's account was adjusted.
- The Net Premium Outstanding is the total of the Beginning Balance less the Total Payments, plus (+) or minus (-) the Total Adjustments.
- The Billing Summary lists the totals of the current month's billing found on the Billing Summary page.
- The Administrative Fee is applied to optional employers (counties, disabilities and special needs boards, water and sewer districts, substance use treatment agencies, special hospital districts, special purpose districts, recreation districts and municipalities).
- Total Net Balance is the total of the Net Premium Outstanding and the current Billing Summary.
- The Employer Share for health, dental, Basic Life and LTD is rolled into one total. Separate totals are provided for the Employee Share for health, Dental Plus, Basic Dental, State Vision Plan, Optional Life, Dependent Life-Spouse, Dependent Life-Child, SLTD and the tobacco-use premium. In addition, a grand total is provided by adding the total employer and employee shares together.

Billing summary pages

The Billing Summary pages show a breakdown of the amount of the current month's bill for all state benefits plans. The health insurance plans are itemized by level of coverage within each plan. The tobacco-use premium will not be included in the health premium amounts; it will appear separately.

This summary itemizes the current monthly premium, showing the amount of the employer share and the employee share for each plan. In addition, separate totals are provided for the current month's figures and for retroactive figures. Also, a current month's figure is provided for the total number of subscribers enrolled in each of the benefit programs.

Coverage processing pages

Coverage Processing provides a detailed list of all enrollments processed since the completion of the last bill. These changes are listed in alphabetical order by the subscriber's last name, with the information displayed only for the state benefits plan(s) affected by the change. If no enrollments are processed, the group will not receive this section.

- Check each transaction listed on the billing statement against any enrollment to make certain the change was processed correctly. If there is a discrepancy in enrollment processing, contact the Customer Contact Center at 803.737.6800 or at 888.260.9430.

- The first column lists the subscriber's name; the date of birth is displayed across the page on the same row.
- The second column shows which insurance program is affected by the coverage processing entry. The alpha and numeric characters for the various state plans are located in the key on the Group Address page of the bill.
- The third column lists which plan category and coverage level the subscriber elected for each type of insurance.
- The fourth column shows the effective date for each type of insurance.
- The next two columns display the employer and employee retroactive premiums and the current rate. The purpose of the current rate is to assist you in reconciling the bill.
- The last column indicates which type of entry is completed for each type of insurance program.
- The grand total for all retroactive figures can be found after the last employee listed in the Coverage Processing pages and on the Billing Summary page of the billing statement for the employer and employee shares.

Remittance advice page

It is important to return this page with your monthly payment to PEBA Insurance Finance for the employer and employee shares. The Grand Total is the total amount due for the current month. These figures are the same figures located at the bottom of the Account Summary page in the Total Net Balance column.

Follow these procedures when completing this page:

- List the amount paid for each benefit down the page starting with the employer share and ending with the tobacco-use premium.
- Verify each payment submitted by adding the amount listed for each state benefits plan to provide a grand total. The grand

total should equal the figure listed for the document total.

- Sign, date and provide a telephone number in the appropriate spaces for the person in each office to contact for questions.

Advance deposit billing statement

Frequency: Annually

Every participating employer, except for CG agencies, is required to make an advance deposit of at least one month's premium for employer contributions. At the beginning of each fiscal year in July, PEBA Insurance Finance bills all participating employers for the advance deposit. Payment is due to PEBA Insurance Finance by July 15.

- This bill lists insurance programs for which the employer contributes to the monthly premium and the subscriber count enrolled in each of these plans at the end of June. The subscriber count is multiplied by the current employer rate to arrive at the deposit amount.
 - On the last page, fill in the amount for one-month deposit or more than one month deposit in the appropriate space. Sign, date and list a telephone number in the space provided for the contact person in your office.
- Those employers that make the one month's advance deposit receive credit to their group account on their bill for the following June, which may result in a balance due or overpayment.
- Those employers that make a yearly deposit receive credit to their group account immediately. This advance deposit for total employer contributions is composed of premiums for these programs according to PEBA Insurance Finance's enrollment files for July:
 - State Health Plan;
 - Basic Dental;

- Basic Life; and
- Basic LTD.

Active billing file

All employers are responsible for reconciling their employer and employee records on a monthly basis. PEBA Insurance Finance provides an Active Billing File as an electronic text file. The billing file may also be provided.

1. A text file (HAC450) that may be downloaded and used in other programs, such as CSI Payroll Services payroll program, is available on EBS for all employers.
2. A text file (HAC460) is easily downloaded into Microsoft Excel.

Contact your PEBA Insurance Finance accounting representative if you wish to change the Active Billing File.

Reports

In addition to your billing statements, PEBA Insurance Finance generates and sends you regular reports to help you notify employees of changes and to help identify errors. Report formats include Text, CSV and PDF.

If you have EBS access, you can access the reports at any time. For those without EBS access, PEBA will send paper copies in the mail. Following is a summary of the reports.

Active subscriber roster (HAC500)

Frequency: Monthly

A list of all employees on file with each group. The month for which it is printed appears directly below the title. Use this to update your records and to verify PEBA Insurance Finance's records. The list provides information on each employee's coverage and the monthly employee premium for each of these programs:

- State Health Plan (the tobacco-use premium will be listed separately) and the GEA TRICARE Supplement Plan;
- Dental Plus;

- Basic Dental;
- State Vision Plan;
- Dependent Life-Spouse;
- Dependent Life-Child;
- Optional Life; and
- SLTD.

Subscriber rosters are listed in alphabetical order by the subscriber's last name. Each subscriber is listed by last name, first name and middle initial. The total number of subscribers and the total amount of employee premiums for each program are on the page following the list of active subscribers.

If there is a discrepancy in enrollment on the membership rosters, call the Customer Contact Center at 803.737.6800 or at 888.260.9430.

Subscriber/dependent roster (HIS539)

Frequency: Monthly

This list shows the type and level for each employee's coverage:

- Health plan (the tobacco-use premium will be listed separately from health coverage);
- Dental Plus;
- Basic Dental;
- State Vision Plan;
- Dependent Life-Child;
- Optional Life;
- Dependent Life-Spouse; and
- SLTD.

This list also shows each employee's spouse and children, the last four digits of their SSNs and the benefits for which each spouse and child is covered, including:

- Health plan;
- Dental Plus;
- Basic Dental;
- State Vision Plan;
- Dependent Life-Child; and
- Dependent Life-Spouse.

Subscribers in SLTD waiver status (HAC555)

Frequency: Monthly (if applicable)

Each group will receive a monthly report listing employees in premium waiver status for SLTD. This report will list the subscriber's name, the BIN, effective date of waiver status and the premium waived.

Optional Life, Dependent Life-Spouse (HAC502) and SLTD age group change (HAC515)

Frequency: Annually (if applicable)

In November of each year, each group receives two reports that list the subscribers who are enrolled in Optional Life, Dependent Life-Spouse and SLTD and who will have a premium adjustment effective the following January due to a change in age bracket. The Optional Life report displays the coverage level and premium amounts for these employees. Subscribers are listed in alphabetical order with full name and birthday. The SLTD report will display only the subscriber's name and the BIN; premiums will not be listed.

Dependent turning 19/25 within 90 days (HIS501) (With Letter [HIS600])

Frequency: Monthly (if applicable)

This report and letter give advance notice to an employee within 90 days of when a child turns age 19 and 25 (for Dependent Life) and age 26 (for all other coverage).

- Send the letter to the employee and include an NOE and necessary COBRA information.
- The employee should complete the NOE and return it to you, so you can make the necessary payroll changes and send it to PEBA for processing.

If the child is incapacitated, the subscriber and dependent's physician must complete the [Incapacitated Child Certification Form](#) and send it to PEBA for review and a

determination. See Page 114 for more details.

Dependent age 1 and older with no SSN (HIS534)

Frequency: Monthly (if applicable)

This report lists subscribers with eligible spouses or children on file without Social Security numbers. The spouse or child will be listed on this report each month until a SSN is provided.

Terminated subscriber listing (HIS512)

Frequency: Monthly (if applicable)

This report lists any subscribers who are terminated from the current month's billing.

- Make sure the proper notification is sent to each listed employee.
- If the termination is in error, submit a corrected Active NOE to PEBA immediately to reinstate the employee's benefits or to correct an incorrectly keyed late entrant date.
- Refer to the key (reminder) at the bottom of the report for proper notification.

Temporary coverage on adoptions ending within 90 days (with letters) (HIS507)

Frequency: Monthly (if applicable)

This report and letter give advance notice to an employee who has added a child to his coverage and is waiting for completion of the one-year final adoption. They are also used to notify you of those employees who failed to furnish the needed final placement agreement at the end of the one-year temporary placement.

- Send the letter to the employee; keep a copy for your files.
- Send an NOE for corrections if the child is no longer eligible.
- Attach a copy of the final adoption/placement agreement to the

employee's letter and return them to PEBA for processing.

- If the child no longer is eligible, provide a copy of the denial for placement letter from the agency and the NOE to delete the child. Notify payroll of any necessary adjustments.

Health subscriber and/or spouse's TEFRA/DEFRA letter

(Tax Equity and Fiscal Responsibility Act/Deficit Reduction Act)

This letter is for your files only. This letter notifies subscribers of their insurance options once they become eligible for Medicare.

- Employees and spouses reaching age 65 are mailed a letter from PEBA 90 days prior to their 65th birthday.
- Letters are mailed the first of each month to the subscriber and/or his spouse.
- A copy is sent to you for your files.

Subscriber premium data file (HAC470)

Frequency: Daily

This report is a daily snapshot of all benefits and premiums for your group's subscribers. It is in a text file format so the data can be manipulated and used to update your payroll without keying the data changes.

For Comptroller General (CG) agencies only

Definitions

Comptroller General (CG) agency: An agency that uses the South Carolina Enterprise Information System (SCEIS) to process its payroll for the employee and employer deductions. SCEIS is the statewide enterprise system used to standardize and streamline business processes within the government of South Carolina. Services include finance, material management, human resources and payroll.

Reconciliation: The comparison of the enrollment files at PEBA and the SCEIS payroll deductions for a subscriber.

Refund: A reimbursement of overpaid insurance premiums to the employee, or to the employer in certain situations.

Submitting premiums for employees on unpaid leave

- Collect the total premium due for unpaid leave employees.
- Submit the personal checks from the employees on unpaid leave, along with an itemized list of the plans/coverage for each. Make sure check includes employee's BIN. A [Personal Checks](#) form is available.
- See Page 143 for more information on unpaid leave rules.

Payroll reconciliation report

PEBA provides a monthly computer reconciliation for all CG agencies. The reconciliation is for the employer and employee share of the monthly premium. The reconciliation for the previous month is forwarded to the agency with the current month's billing statement. Each CG agency receives a printout of differences for the following state benefits plans:

- State Health Plan (the tobacco-use premium will be listed separately) and the GEA TRICARE Supplement Plan;
- Dental Plus;
- Basic Dental;
- State Vision Plan;
- Optional Life;
- Dependent Life Spouse;
- Dependent Life-Child; and
- SLTD.

Reconciliation for all of these plans follows the same basic format. The reconciliation report lists the subscriber(s) who is being billed a different amount than the deducted premium. Under the Insurance Master section is the amount of the

coverage on the PEBA computer system. Under the SCEIS Deduction section is the amount that is payroll deducted. Listed in the next column is the difference between the two. At the end of each type of insurance are the totals for the Insurance Master section, the SCEIS Deduction section and the Difference column.

Investigate each exception and take proper action to correct the problem.

PEBA sends an enrollment file to SCEIS on a daily basis. SCEIS uses the information on the file (benefit, effective date, type of entry, coverage level and premium) to determine the premiums to be deducted on the next payroll.

SCEIS payroll process

- SCEIS collects and remits to PEBA the employer and employee premiums based on the daily files. Your group will continue to receive a bill; however, your group should not remit payments for the monthly employer premiums or the Advance Deposit.
- Contact the SCEIS Help Desk with questions concerning which account the employer premiums are taken from or the funding source for the employer premiums.
- SCEIS will not process a refund check for amounts less than \$1; therefore, an adjustment must be requested to zero out the employee's balance.
- For a new hire or coverage change that results in a large balance due, your group may decide to collect premiums due over several pay periods. You should contact the SCEIS Help Desk to change the amount of the deduction and the number of pay periods.
- You may continue to send personal checks for the employee premiums for subscribers in unpaid leave status. If you do not collect the monthly premium from a subscriber while he is in unpaid leave status, SCEIS will collect the total amount due from the first

payroll check the subscriber receives once he is no longer in unpaid leave status. If you remit the monthly premiums, you should notify SCEIS that the payments have been sent to PEBA so they will not deduct the incorrect amount. SCEIS will continue to remit the monthly employer premiums for the subscriber while he is in unpaid leave status.

- If you discover an enrollment error on the billing statement, you should contact PEBA to resolve the enrollment error, which should correct the deduction. If the coverage is correct but the payroll deductions are not, you should contact the SCEIS Help Desk to resolve the problem.
- PEBA will continue to provide the Reconciliation and the Accumulator reports for all SCEIS groups. PEBA will also provide the Reconciliation and Accumulator reports for the employer share.

Unclaimed refund checks

If the U.S. Postal Service returns a refund check to your group as undeliverable, the check, along with the envelope returned from the U.S. Postal Service stating it was unable to deliver the refund check, should be forwarded to PEBA. The overpayment of premiums will become a part of the Unclaimed Property maintained by the Office of the State Treasurer. Former employees can search by their name to locate any unclaimed funds due to them at <http://treasurer.sc.gov/>.

For optional employers only

Definitions

Administrative fee: Optional employers must pay a \$3 administrative fee for each employee, retiree, survivor, COBRA participant and former spouse per month. Employers cannot pass this fee to active employees and COBRA participants. An employer may require retirees, survivors and former spouses to pay this fee.

Experience rating: Optional employers are subject to experience rating of health insurance premiums. Employer contributions and subscriber premiums may be different than those published in PEBA publications.

Experience rating health premiums

The experience rating, a load factor, or a percentage amount is added to the optional employer's health premiums based on claims history. This load factor is adjusted each year using the past two plan years' worth of claims experience.

PEBA calculates the experience rating of all optional employers annually. Employers will receive written notification of their load factor each March, and the load factor will be applied in January of the following year. Both the employer and employee shares of the total premium will change, and an employer may choose to absorb some or all of any increase in the employee share. However, an employer may **not** pass along any of the employer share of the increase to the employee. The employer is responsible for notifying its subscribers of any rate changes.

Rate changes due to experience rating are separate and are in addition to any annual, across-the-board rate increases.

When optional employers initially join the State insurance benefits program, they are categorized by size — by the number of covered lives (number of individuals insured under the program). Initial health premiums are rated according to the average claims experience of other employers in their category.

Optional employers are separated into three categories based on the number of covered lives:

- Small: fewer than 100 covered lives. Rated according to average claims experience of all the small employers.
- Medium: 100-500 covered lives. Once 24 months of claims are incurred for an

employer, rated using a formula that gives 50 percent weight to the average claims experience of all medium employers combined and 50 percent weight to the claims experience of the individual employer.

- Large: more than 500 covered lives. Once 12 months of claims are incurred for an employer, rated solely on the claims experience of that employer.

This rate, or load factor, is applied to the current premiums and remains in effect until the employer has incurred enough claims to be rated using the same formula as other employers in their category.

Bills - Retiree, COBRA and Survivor (HRA610)

The billing statement for retiree, COBRA and survivor subscribers is the same as that for active subscribers except for the differences noted below.

- State Health Plan;
- GEA TRICARE Supplement Plan;
- Dental Plus;
- Basic Dental;
- Vision care; and
- Tobacco-use premium.

Account summary pages

The administrative fee is \$3 for each employee, retiree, survivor, COBRA participant and former spouse per month. An employer may require retirees to pay this fee.

Remittance advice page

The instructions for the remittance advice page are the same as for active subscribers, but note that the layout is different for retiree, COBRA and survivor subscribers. Note that some programs are not listed, because they are not available to these subscribers.

Retiree, COBRA and Subscriber Roster (HRA500)

Frequency: Monthly

This list provides information on each retiree, COBRA and survivor subscriber's coverage and the monthly employee premium for each of the following state benefits plans:

- State Health Plan;
- Dental Plus;
- Basic Dental;
- Vision care; and
- Tobacco-use premium.

The roster is divided into sections based on subscriber type (18-month COBRA, 29-month COBRA, 36-month COBRA, Retiree-Regular, Retiree-25 Year, etc.). In each of the sections, names are printed in alphabetical order by last name, first name and middle initial, with the BIN listed in the next column. This roster will not include the SSN.

Submitting premium payments to PEBA

All balances are due to PEBA on the 10th of the month and must be paid as billed. If there is a keying error on the coverage processing section of the bill, please call the Customer Contact Center at 803.737.6800 or at 888.260.9430. If payment is not remitted by the 10th, employers will risk suspension of claims payments for their employees.

- Do not adjust the billing statement.
- Do not delay the regular remittance of monthly premiums due to inability to collect payments from subscribers.
- Employers must pay no less than the current employer share of the premiums for their active employees.

There are three ways to remit payments to PEBA.

By check

All checks should be made payable to PEBA. If your office also pays for retiree, survivor and COBRA subscriber coverage, submit one check for these premiums. See also Submitting premiums for employees on unpaid leave.

You must return a completed remittance advice form with every payment. Do not return any other section of the billing statement with your payment. Use the return envelope provided, or mail your payment to Insurance Finance Department.

Mailing address:

S.C. PEBA
Attn: Insurance Finance Department
P.O. Box 11661
Columbia, SC 29211

Electronic Funds Transfer (EFT)

Employers also have the option to pay their monthly premiums through Electronic Funds Transfer, or automatic draft. This payment method gives PEBA authorization to automatically deduct your monthly premium balance from your designated bank account. You will continue to receive a monthly billing statement, which gives the amount that will be drafted from your bank account on the 10th of the following month.

If the 10th falls on a weekend or holiday, the draft will occur on the next business day.

To enroll, please complete an [Authorization Agreement for Electronic Funds Transfer](#). Submit it with a voided check from your designated bank account. After we receive your authorization, it will take about 31 days for the automatic draft to begin.

Premiums for active employees

School districts, higher education institutions and optional employers

- A single check from the employer, for the total premiums for active employees and matching the total amount due on the monthly Active Group Billing Statement, should be sent to PEBA.

- The check must also include premiums for any covered employees on unpaid leave as noted in the statement.
- Do not submit individual checks from your employees. See also Submitting premiums for employees on leave without pay below.

CG agencies

CG agencies may forward to PEBA individual checks received from covered employees on LWOP. See Submitting premiums for employees on leave without pay to the right.

Premiums for retiree, survivor and COBRA subscribers

CG agencies, school districts and higher education institutions

- Since PEBA becomes the benefits administrator for these subscribers, they will receive a bill from PEBA. Retirees, who have their premiums deducted from their retirement checks or auto-drafted from a bank account, do not receive a bill.
- These subscribers submit their personal checks, payable to PEBA, with their bill.

Optional employers

- Since the employer continues to serve as the benefits administrator for these subscribers, the employer will receive the Retiree, COBRA and Survivor bill in EBS, which will include the premiums for these subscribers.
- A single check from the employer for the amount of premiums for these subscribers that matches the total amount due on the monthly Retiree, COBRA and Survivor bill should be included in the check remitted for active employees.
- Collect the premiums for covered retirees, COBRA and survivor subscribers and deposit their checks into your account. Their checks should be made payable to the employer, **not** PEBA. Do not submit personal checks to PEBA.

- Subscriber questions regarding the premium amounts or billing should be directed to the employer.

Submitting premiums for employees on unpaid leave

School districts, higher education institutions and optional employers

- Premiums billed for employees on unpaid leave are included on the monthly active group billing statement. Include the amount of premiums for employees on unpaid leave in your check for active employees.
- Collect the premiums due for covered employees on unpaid leave. Their checks should be made payable to the employer, **not** PEBA. Do not submit personal checks to PEBA.
- Deposit the collected unpaid leave premiums into your group account.

CG agencies only

- Premiums billed for employees on unpaid leave are included on the monthly Active Group Billing Statement. Only CG agencies may send employees' personal checks to PEBA while they are on unpaid leave.
- Collect the total premiums due for covered employees on unpaid leave.
- Submit the personal checks received from employees on unpaid leave, along with an itemized list of the amounts paid for each plan/coverage and the employee's BIN. These personal checks should be made payable to PEBA.
- A [Personal checks](#) form is available to send with the checks. A copy of the Remittance Advice page may be used as long as the BIN is provided.

Premium checks quick reference

Type of employer	Submitting insurance checks to PEBA Insurance Finance		
	Active employee	Unpaid leave	Retiree/COBRA/Survivor
Optional employer	Single check from employer to include all active premiums as billed by PEBA Insurance Finance.	Single check from employer; include with active group as billed. No personal checks to PEBA Insurance Finance.	Include all premiums for these subscribers in the check for active employees. No personal checks to PEBA Insurance Finance.
CG agency	Employee and employer premiums are payroll-deducted by SCEIS and sent directly to PEBA Insurance Finance.	Submit personal checks, payable to PEBA Insurance Finance.	PEBA Insurance Finance bills subscribers. Subscribers submit personal checks to PEBA Insurance Finance or have premiums deducted from PEBA retirement benefits annuity payment or other account.
School district	Single check from employer to include all active premiums as billed by PEBA Insurance Finance.	Single check from employer; include with active group as billed. No personal checks to PEBA Insurance Finance.	PEBA Insurance Finance bills subscribers. Subscribers submit personal checks to PEBA Insurance Finance or have premiums deducted from PEBA retirement benefits annuity payment or other account.
Higher education institution	Single check from employer to include all active premiums as billed by PEBA Insurance Finance.	Single check from employer; include with active group as billed. No personal checks to PEBA Insurance Finance.	PEBA Insurance Finance bills subscribers. Subscribers submit personal checks to PEBA Insurance Finance or have premiums deducted from PEBA retirement benefits annuity payment or other account.

Annual SLTD salary updates

All salaries must be reviewed and updated annually during open enrollment. There is a separate process for Comptroller General (CG) payroll groups.

To update SLTD premiums correctly for the next plan year, PEBA needs updated salary information for your employees who are enrolled in SLTD. If your employer is not a part of the CG payroll group, submit your SLTD updated salaries as of October 1 of each year through EBS. Submit updated salaries no later than October 30. The salary on which SLTD premiums are based should include the employee's base rate of pay for the hours they are regularly scheduled to work, plus any of the following that apply to the employee:

- Longevity pay;
- Shift differential pay;
- Regular compensation earned by university teaching staff during regular summer sessions; and
- Contributions the employee makes to deferred compensation plans or fringe benefits (like payroll deductions for health insurance).

Do not include overtime pay, commissions, bonuses, employer contributions to benefits, or any other extra compensation.

If you do not update the salary information, premiums will be based on the most recent information submitted to PEBA Insurance Finance. Any benefits paid also will be based on the most recent information submitted to PEBA Insurance Finance.

You should include data for those who have had a salary change since the previous October 1.

Example: If an employee was hired March 2020 with a salary of \$25,000, and he has received a salary increase of \$3,000, and his salary as of October 1 includes this increase,

you must submit the updated salary of \$28,000 to PEBA.

The maximum annual salary for calculating SLTD benefits and premiums is \$147,684. If PEBA receives any salary updates that exceed this amount, the amount entered into the system will default to the maximum. PEBA will notify employers if the amount changes.

Groups affected by furloughs should use employees' non-furlough salaries to calculate premiums.

If you have any questions or problems regarding submitting SLTD salary information, please contact the Customer Contact Center at 803.737.6800 or 888.260.9430.

Affordable Care Act

The Patient Protection and Affordable Care Act, also known as the Affordable Care Act (ACA), is the health reform legislation signed into law in March 2010. Key provisions of the legislation include extending coverage to millions of uninsured Americans, implementing measures that will lower health care costs and eliminating industry practices that include denial of coverage due to preexisting conditions.

The ACA does not require businesses to provide health benefits to their workers, but applicable large employers may face penalties if they don't make affordable coverage available. The Employer Shared Responsibility Provision of the ACA penalizes employers who either do not offer coverage or do not offer coverage that meets minimum value and affordability standards.

As a participating employer in PEBA insurance benefits, you must offer coverage to all employees eligible to participate in the insurance benefits. The [Plan of Benefits](#) document has been amended to allow coverage for permanent full-time employees, as well as non-permanent full-time employees and variable-hour, part-time and seasonal employees.

PEBA offers “grandfathered health plans” under the ACA. As a grandfathered plan, PEBA will be able to minimize the increase in State Health Plan premiums while it assesses the future financial impact of the act. As permitted by the ACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when the law was enacted.

Being a grandfathered health plan means that the plan may not include certain consumer protections of the ACA that apply to other plans, such as the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the ACA, such as the elimination of lifetime limits on benefits.

For ACA resources, including frequently asked questions and reporting requirements, go to www.peba.sc.gov/aca.html.

MoneyPlus payrolls and accounting

Each employer is responsible for sending funds to ASIFlex and for timely reporting of payroll deductions to these accounts to ensure uninterrupted claim processing for employees. The [ASIFlex Employer Payroll User Quick Guide](#) provides an overview of the process; describes your ongoing duties regarding when and how to report deductions; discusses how ASIFlex identifies and reports account discrepancies to you; and tells you how to respond to and resolve discrepancies.

Nondiscrimination testing

To remain tax free under Internal Revenue Code sections 105, 125 and 129, the MoneyPlus plan must pass several nondiscrimination tests.

One of these tests, the 55 percent Average Benefits Test, requires that all eligible employees’ gross compensation be collected. This test is vital in determining the South Carolina MoneyPlus plan’s

compliance with Internal Revenue Service (IRS) nondiscrimination rules.

PEBA will perform this test within the first 60 days of any given plan year.

This is for your information only, PEBA will contact you directly if they need any information for the purpose of nondiscrimination testing.

Imputed income (taxable portion of Optional Life premiums)

Optional Life (OL) insurance coverage in excess of \$50,000 is considered imputed income (taxable) by the IRS when the premium for this coverage is paid through the MoneyPlus Pretax Group Insurance Premium feature. The imputed income is based on an employee’s age and amount of OL coverage in excess of \$50,000. It is added to the employee’s salary and is subject to federal income tax and FICA. The taxable portion of the OL coverage will always be the amount over \$50,000 of the total coverage, regardless of any employer contributions.

Imputed income rate table (2020 tax year)

Age category	Rate per \$1,000 in coverage beyond \$50,000
Younger than 25	0.05
25-29	0.06
30-34	0.08
35-39	0.09
40-44	0.10
45-49	0.15
50-54	0.23
55-59	0.43
60-64	0.66
65-69	1.27
70 and older	2.06

Imputed income is calculated based on the IRS rate table above. The IRS may change these rates periodically. Each \$1,000 of OL coverage beyond \$50,000 is multiplied by the monthly rate for the applicable age group. The employer is responsible for reporting the imputed income amounts on employees' W-2 forms.

In early December, after open enrollment changes have been updated, PEBA will provide an EBS report of employees enrolled with OL coverage over \$50,000. The data will include the employee's name, BIN, effective date, level of coverage, age group, date of birth and the non-taxable/taxable amounts of the OL premiums. PEBA will continue to provide a monthly report of this information, including new hires and changes to OL due to a special eligibility event.

At the end of the year, PEBA will provide an imputed income report so you can adjust the employees' W-2 forms accordingly.

Your employer group may choose to deduct the taxable and non-taxable premium amounts separately each pay period. If your group accounts for the taxable portion of the OL premiums for employees throughout the year on all payrolls, you will only need to use the year-end OL/imputed income report from PEBA for comparison purposes.

Important reminders in calculating imputed income

- Each \$1,000 of coverage beyond \$50,000 should be multiplied by the monthly rate for the applicable age group in the IRS rate table on the previous page. This monthly amount may be multiplied by 12 to get an annual amount. Imputed income for employees who were enrolled only part of the year should be prorated.
- Unlike calculating PEBA OL premiums, which are based on the employee's age category as of the *previous* December 31, imputed income is calculated by the IRS, based on the employee's age category as of December 31 of the *current* year. For example, for the 2019 tax year, if an employee turns age 50 in September, his IRS-imputed income for 2019 is based on the rate for the 50-54 age category in the IRS rate table, even though his 2019 OL premium is based on the age 45-49 category.
- Instead of one age category for OL premiums for those younger than 35, there are three age categories in the IRS imputed income rate table for those younger than 35: younger than 25, 25-29 and 30-34. Also, the last category in the imputed income rate table is for those ages 70 and older; the last age category for OL premiums is 80 and older.

Example: An employee, who elected \$180,000 in OL coverage, turns age 40 in October 2019. His monthly OL premium on \$180,000 in coverage is \$14.04, based on his age category the previous December 31.

His imputed income would be calculated like this:

1. $\$180,000 - \$50,000 = \$130,000$
2. $\$130,000 \div 1,000 = \130 (the per-thousand amount)
3. 130×0.10 (the rate for the age 40-44 category from the IRS imputed income rate table) = \$13.00 per month. This is the taxable monthly amount of imputed income.

Reclassification of outstanding debit card transactions

Payback report

Each fall, ASIFlex will send benefits administrators a payback report that lists any employees with outstanding debit card transactions. This report includes a summary and detail. The summary shows the total amount due. The detail portion of the report shows each individual transaction (by SSN and name).

If an employee is on this report:

- The employee has been notified about the outstanding transaction(s) at least twice;
- The outstanding transaction(s) is at least 70 days old; and
- His card has been suspended.

The employee has until the end of the run-out period (March 31 following the end of the plan year) to clear up any outstanding expenses and reinstate the card.

You are encouraged to use this report to communicate with any employees listed on it and remind them:

- To submit their documentation or they will face tax consequences (see Reclassification as follows); and
- Their card will be suspended if there are any transactions that have not been cleared up by the end of the run-out period.

Reclassification

If the employee does not clear up the outstanding transactions, the unsubstantiated amounts must be reclassified as taxable income, and that employee's W-2 must be amended to reflect that amount.

Example: For the 2020 plan year, an employee has an outstanding card transaction of \$50. That employee has until March 31, 2021, to clear up the expense by:

- Submitting the necessary documentation to substantiate the claim;
- Filing a paper claim or claims that will offset the outstanding card transaction amount; or
- Writing a check made payable to the State of South Carolina and mailing it to ASIFlex, SC MoneyPlus, P.O. Box 6044, Columbia, MO 65205-6044. This check will repay his account for the amount of the outstanding card transaction amount.

If the outstanding transaction amount is not cleared up by one of these methods, the amount is taxable as income. Since this amount cannot be confirmed until after the end of the tax-reporting period (April 15, 2021), the amount will be reported for the 2021 tax year. In November 2021, the benefits administrator will receive a list from ASIFlex that will include the employee's name and the amount to be added to his taxable income on his 2021 W-2, which will be issued to him in early 2022.

For CG agencies, ASIFlex will send a file to the Comptroller General's Office to include the unsubstantiated amounts on the employee's W-2. Your accountant/auditor can discuss the proper W-2 application.



Reference

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Acronyms used in this manual

Acronym	Explanation
AD&D	Accidental Death & Dismemberment
BA	Benefits administrator
BlueCross	BlueCross BlueShield of South Carolina
BIN	Benefits ID number (subscriber identification number in lieu of SSN)
BLTD	Basic Long Term Disability
CBA	Companion Benefit Alternatives
CG	Comptroller General
COBRA	Consolidated Omnibus Budget Reconciliation Act
DCSA	Dependent Care Spending Account (MoneyPlus)
DHHS	Department of Health and Human Services (Medicaid)
DSS	Department of Social Services
EBS	Employee Benefits Services
ERISA	Employee Retirement Income Security Act
FSA	Flexible Spending Account (MoneyPlus)
FMLA	Family and Medical Leave Act of 1993
GEA	Government Employees Association, sponsor of the TRICARE Supplement Plan
HIPAA	Health Insurance Portability and Accountability Act of 1996
HMO	Health Maintenance Organization
HSA	Health Savings Account
IBG	<i>Insurance Benefits Guide</i>
LTC	Long term care
LTD	Long term disability
MSA	Medical Spending Account (MoneyPlus)
NOE	<i>Notice of Election</i>
PEBA	Public Employee Benefit Authority
PCP	Primary care physician
PPACA (ACA)	Patient Protection and Affordable Care Act
RETRO	Retroactivity
SCEIS	South Carolina Enterprise Information System
SLTD	Supplemental long-term disability
SOC	Summary of change
SOE	Summary of enrollment
SOI	Summary of intent
SSN	Social Security number
STARS	Statewide Accounting and Reporting System
SVP	State Vision Plan
URT	Unrequested refund transfer
USERRA	Uniformed Services Employment and Reemployment Rights Act

County codes

1	Abbeville
2	Aiken
3	Allendale
4	Anderson
5	Bamberg
6	Barnwell
7	Beaufort
8	Berkeley
9	Calhoun
10	Charleston
11	Cherokee
12	Chester
13	Chesterfield
14	Clarendon
15	Colleton
16	Darlington
17	Dillon
18	Dorchester
19	Edgefield
20	Fairfield
21	Florence
22	Georgetown
23	Greenville
24	Greenwood
25	Hampton
26	Horry
27	Jasper
28	Kershaw
29	Lancaster
30	Laurens
31	Lee
32	Lexington
33	McCormick
34	Marion
35	Marlboro
36	Newberry
37	Oconee
38	Orangeburg
39	Pickens
40	Richland
41	Saluda
42	Spartanburg
43	Sumter
44	Union
45	Williamsburg
46	York
99	Out-of-state

Quick reference charts

Active NOE quick reference

Use EBS when permissible. Instructions for the [Active Notice of Election](#) form are on Page 3 of the form. This chart includes specific details for additions and changes when using the NOE.

NOE section	New hire	Open enrollment	Marriage	Divorce/separation
ACTION	New Hire; Specify Enrollment.	Type of Change; Specify Enrollment.	Type of Change; Other (Marriage); Date of Change Event. Must provide documentation.	Type of Change; Other (Divorce or Separation); Date of Change Event. Must provide documentation.
BA USE ONLY	Effective Date; Group ID#; Group Name; if 20-hour employee; Pay periods per year.	Effective Date; Group ID#; Group Name; Pay periods per year.	Effective Date; Group ID#; Group Name; Pay periods per year.	Effective Date; Group ID#; Group Name; Pay periods per year.
ENROLLEE INFO	#1-19	#1-5	#1-5; #8-17	#1-5; #8-17
COVERAGE*	#20-26	#20-22, 23-24, 26, if applicable.	#20-24, 26 if changing coverage level.	#20-24, 26 if changing coverage level.
MONEYPLUS PreTax Premiums	Refuse or Yes.	Complete if changing election.	Complete if changing election.	Complete if changing election.
MONEYPLUS Elections	Complete if enrolling.	Complete if re-enrolling or enrolling.	Complete if changing election.	Complete if changing election.
EMPLOYEE INITIALS	Initial and date.	Initial and date.	Initial and date.	Initial and date.
MEDICARE	Complete all, if applicable.	Complete all, if applicable.	Complete all, if applicable.	Complete all, if applicable.

For Beneficiaries and Dependents:

Do **not** list “spouse” or “child.” List relationship as wife, husband, daughter, son, etc.

For Beneficiaries:

An estate or trust has no relationship.

BENEFICIARIES*	Complete all.	Employee option to change; complete all, if applicable.	Employee option to change; complete all, if applicable.	Employee option to change; complete all, if applicable.
DEPENDENTS	Complete all, if applicable.	Complete all, if applicable.	Add; complete all, listing dependents to add.	Delete; listing dependents to delete.
CERTIFICATION & AUTHORIZATION	#31-32	#31-32	#31-32	#31-32

*Absolutely no alterations are allowed in this section.

Active NOE quick reference (cont.)

NOE section	Ineligible child/coverage change	Last ineligible child/coverage change	Returning student	Dependent Life-Spouse coverage with medical approval
TYPE OF CHANGE	Change; Other (ineligible child; give reason).	Change; Other (ineligible child; give reason).	Change; Other (returning student). Must provide documentation.	Change; Other (Dependent Life and increase with medical approval). Must provide approval from MetLife.
BA USE ONLY	Effective Date; Group ID#; Group Name.	Effective Date; Group ID#; Group Name.	Effective Date; Group ID#; Group Name.	Effective Date; Group ID#; Group Name.
ENROLLEE INFO	#1-5	#1-5	#1-5	#1-5
COVERAGE*	#20-22 and 26 if decreasing coverage level.	#20-22 and 26 if decreasing coverage level.	#20-22 and 26 if decreasing coverage level.	#23
MONEYPLUS PreTax Premiums	Complete if changing election.	Complete if changing election.	Complete if changing election.	N/A
MEDICARE	Complete all, if applicable.	Complete all, if applicable.	Complete all, if applicable.	Complete all, if applicable.

For Beneficiaries and Dependents:

Do **not** list “spouse” or “child.” List relationship as wife, husband, daughter, son, etc.

For Beneficiaries:

An estate or trust has no relationship.

BENEFICIARIES*	Employee option to change; complete all, if applicable.	Employee option to change; complete all, if applicable.	Employee option to change; complete all, if applicable.	Employee option to change; complete all, if applicable.
DEPENDENTS	Delete; list child to delete.	Delete; list child to delete.	Add; complete all, listing child to add.	Add; listing spouse.
CERTIFICATION & AUTHORIZATION	#31-32	#31-32	#31-32	#31-32

*Absolutely no alterations are allowed in this section.

Active NOE quick reference (cont.)

NOE section	Optional Life add/increase	Optional Life add/increase with medical approval	Optional Life decrease/refuse	Dependent Life add/increase with medical approval	SLTD add/decrease waiting period with medical approval
TYPE OF CHANGE	Change; Other (OL add or increase); give reason.	Change; Other (OL add or increase with medical approval) Must provide approval from MetLife.	Change; Other (OL decrease or refuse); give reason for change if on MoneyPlus.	Change; Other (DL add or increase with medical approval) Must provide approval from MetLife.	Change; Other (SLTD add or wait period) Must provide approval from The Standard.
BA USE ONLY	Effective Date; Group ID#; Group Name.	Effective Date; Group ID#; Group Name.	Effective Date; Group ID#; Group Name.	Group ID#; Group Name.	Group ID#; Group Name.
ENROLLEE INFO	#1-5; 18	#1-5; 18	#1-5	#1-5; 18	#1-5
COVERAGE*	#24 (enter new amount).	#24 (enter new amount).	#24 (enter new amount or refuse).	#23 (enter new amount).	#25
MONEYPLUS PreTax premiums	Complete if changing election.	Complete if changing election.	Complete if changing election.	N/A	N/A
MEDICARE	Complete all, if applicable.	Complete all, if applicable.	Complete all, if applicable.	Complete all, if applicable.	Complete all, if applicable.

For Beneficiaries:

Do **not** list “spouse” or “child.” List relationship as wife, husband, daughter, son, etc.

An estate or trust has no relationship.

BENEFICIARIES*	Employee option to change; complete all, if applicable.	Employee option to change; complete all, if applicable.	Employee option to change; complete all, if applicable.	Employee option to change; complete all, if applicable.	Employee option to change; complete all, if applicable.
DEPENDENTS	N/A	N/A	N/A	N/A	N/A
CERTIFICATION & AUTHORIZATION	#31-32	#31-32	#31-32	#31-32	#31-32

*Absolutely no alterations are allowed in this section.

Special eligibility situations quick reference

This information describes changes subscribers can make when a special eligibility situation occurs. Unless otherwise noted, all changes must be made within 31 days of the event.

Event	This person/these people <i>(select one)</i>	Can do one or more of these actions <i>(select as many as apply)</i>	Effective date	Documentation required
Birth of child	<input type="checkbox"/> Employee alone <input type="checkbox"/> Employee and newborn child <input type="checkbox"/> Employee and existing child(ren) <input type="checkbox"/> Employee and spouse <input type="checkbox"/> Employee, spouse, existing child(ren) and newborn child	<input type="checkbox"/> Enroll in health (if employee already enrolled in health, may change plans if adding spouse or child to health) <input type="checkbox"/> Enroll in Dental Plus or Basic Dental <input type="checkbox"/> Enroll in State Vision <input type="checkbox"/> Enroll in Dependent Life-Child <input type="checkbox"/> Enroll in or increase Dependent Life-Spouse (\$10,000 or \$20,000 without evidence of insurability; more than \$20,000 with evidence of insurability) <input type="checkbox"/> Enroll in or increase Optional Life (up to \$50,000 without evidence of insurability; more than \$50,000 with evidence of insurability) <input type="checkbox"/> Review changes available with MSA/DCSA	Health, dental and vision: Date of birth Optional Life and Dependent Life-Spouse: For amounts available without evidence of insurability, first of month following date of request. For amounts requiring evidence of insurability, first of month following date of approval. Dependent Life-Child: Date of birth	Long-form birth certificate of child and if adding spouse, marriage license or Page 1 of most recent tax return.
Notes A. May not drop any coverage; may only change or add coverage. B. For Optional Life, if employee is not actively at work on the expected effective date, then the effective date will be first of the month following return to work. For Dependent Life, if dependent, other than a newborn, is confined to a hospital or elsewhere on the expected effective date, then the effective date will be deferred until the spouse or child is discharged from the hospital or no longer confined.				

Special eligibility situations quick reference (cont.)

Event	This person/these people <i>(select one)</i>	Can do one or more of these actions <i>(select as many as apply)</i>	Effective date	Documentation required
Adoption of child (or placement for adoption)	<input type="checkbox"/> Employee alone <input type="checkbox"/> Employee and newly adopted child <input type="checkbox"/> Employee and existing child(ren) <input type="checkbox"/> Employee and spouse <input type="checkbox"/> Employee, spouse, existing child(ren) and newly adopted child	<input type="checkbox"/> Enroll in health (if employee already enrolled in health, may change plans if adding spouse or child to health) <input type="checkbox"/> Enroll in Dental Plus or Basic Dental <input type="checkbox"/> Enroll in State Vision <input type="checkbox"/> Enroll in Dependent Life-Child <input type="checkbox"/> Enroll in or increase Dependent Life-Spouse (\$10,000 or \$20,000 without evidence of insurability; more than \$20,000 with evidence of insurability) <input type="checkbox"/> Enroll in or increase Optional Life (up to \$50,000 without evidence of insurability; more than \$50,000 with evidence of insurability) <input type="checkbox"/> Review changes available with MSA/DCSA	<p>Health, dental and vision: Date of adoption or placement for adoption, UNLESS baby is adopted or placed for adoption within 31 days of birth — then date of birth.</p> <p>Optional Life and Dependent Life-Spouse: For amounts available without medical evidence, first of month following date of request. For amounts requiring evidence of insurability, first of month following date of approval.</p> <p>Dependent Life-Child: Date of birth for newborns. First of the month after date of request for other children.</p>	<p>Long-form birth certificate listing the subscriber as the parent; legal adoption documentation from court, verifying adoption completed; or letter of placement from adoption agency, attorney, or DSS verifying adoption in progress</p> <p>and</p> <p>if adding spouse, marriage license or Page 1 of most recent tax return.</p>
Notes A. May not drop any coverage; may only change or add coverage. B. For Optional Life, if employee is not actively at work on the expected effective date, then the effective date will be first of the month following return to work. For Dependent Life, if dependent, other than a newborn, is confined to a hospital or elsewhere on the expected effective date, then the effective date will be deferred until the spouse or child is discharged from the hospital or no longer confined.				

Special eligibility situations quick reference (cont.)

Event	This person/these people <i>(select one)</i>	Can do one or more of these actions <i>(select as many as apply)</i>	Effective date	Documentation required
Placement of foster child (with court order) <i>If you have gained legal custody of your foster child, see Gains custody of child</i>	<input type="checkbox"/> Employee alone <input type="checkbox"/> Employee and new foster child <input type="checkbox"/> Employee and existing child(ren) <input type="checkbox"/> Employee and spouse <input type="checkbox"/> Employee, spouse, existing child(ren) and new foster child	<input type="checkbox"/> Enroll in health (if employee already enrolled in health, may change plans if adding spouse or new foster child to health) <input type="checkbox"/> Enroll in Dental Plus or Basic Dental <input type="checkbox"/> Enroll in State Vision <input type="checkbox"/> Review changes available with MSA/DCSA	Health, dental and vision Date of placement (usually date of court order). <i>If enrolled in MoneyPlus Pretax Premium feature, premiums must be paid post-tax for retroactive coverage back to the date of gaining child. Premiums may be paid through the Pretax Premium feature beginning first of the month following date of request.</i>	Court order placing child in foster care with the employee and if adding spouse, marriage license or Page 1 of most recent tax return.
Notes				
A. May not drop any coverage; may only change or add coverage.				

Special eligibility situations quick reference (cont.)

Event	This person/these people <i>(select one)</i>	Can do one or more of these actions <i>(select as many as apply)</i>	Effective date	Documentation required
Gains custody of child (with court order)	<input type="checkbox"/> Employee alone <input type="checkbox"/> Employee and child for whom he gained legal custody <input type="checkbox"/> Employee and existing child(ren) <input type="checkbox"/> Employee and spouse <input type="checkbox"/> Employee, spouse, existing child(ren) and child for whom he gained legal custody	<input type="checkbox"/> Enroll in health (if employee already enrolled in health, may change plans if adding spouse or child to health) <input type="checkbox"/> Enroll in Dental Plus or Basic Dental <input type="checkbox"/> Enroll in State Vision <input type="checkbox"/> Enroll in Dependent Life-Child <input type="checkbox"/> Review changes available with MSA/DCSA	Health, dental and vision Date of court order Dependent Life-Child Date of birth for newborns. First of the month after date of request for other children. <i>If enrolled in MoneyPlus Pretax Premium feature, premiums must be paid post-tax for retroactive coverage back to the date of gaining child. Premiums may be paid through the Pretax Premium feature beginning first of the month following date of request.</i>	Court order granting custody of the child to employee and if adding spouse, marriage license or Page 1 of most recent tax return.
Notes				
A. May not drop any coverage; may only change or add coverage. B. For Dependent Life, if dependent, other than a newborn, is confined to a hospital or elsewhere on the expected effective date, then the effective date will be deferred until the spouse or child is discharged from the hospital or no longer confined.				

Special eligibility situations quick reference (cont.)

Event	This person/these people (<i>select one</i>)	Can do one or more of these actions (<i>select as many as apply</i>)	Effective date	Documentation required
Marriage	<input type="checkbox"/> Employee alone <input type="checkbox"/> Employee and any new stepchild <input type="checkbox"/> Employee and existing child(ren) <input type="checkbox"/> Employee and spouse <input type="checkbox"/> Employee, spouse, existing child(ren) and any new stepchild	<input type="checkbox"/> Enroll in health (if employee already enrolled in health, may change plans if adding spouse or stepchild to health) <input type="checkbox"/> Enroll in Dental Plus or Basic Dental <input type="checkbox"/> Enroll in State Vision <input type="checkbox"/> Enroll in Dependent Life-Spouse (\$10,000 or \$20,000 without medical evidence; more than \$20,000 with evidence of insurability) <input type="checkbox"/> Enroll in Dependent Life-Child <input type="checkbox"/> Enroll in or increase Optional Life (up to \$50,000 without evidence of insurability; more than \$50,000 with evidence of insurability) <input type="checkbox"/> Review changes available with MSA/DCSA	Health, dental and vision: Date of marriage Optional Life and Dependent Life-Spouse: For amounts available without evidence of insurability, first of month following date of request. For amounts requiring evidence of insurability, first of month following date of approval. Dependent Life-Child: First of the month after date of request. <i>If enrolled in MoneyPlus Pretax Premium feature, premiums must be paid post-tax for retroactive coverage back to the date of marriage. Premiums may be paid through the Pretax Premium feature beginning first of the month following date of request.</i>	Marriage license and if adding stepchildren, also need long-form birth certificates for each child.
Notes A. May not drop any coverage; may only change or add coverage. B. For Optional Life, if employee is not actively at work on the expected effective date, then the effective date will be first of the month following return to work. For Dependent Life, if dependent, other than a newborn, is confined to a hospital or elsewhere on the expected effective date, then the effective date will be deferred until the spouse or child is discharged from the hospital or no longer confined.				

Special eligibility situations quick reference (cont.)

Event	This person/these people <i>(select one)</i>	Can do one or more of these actions <i>(select as many as apply)</i>	Effective date	Documentation required
Divorce	<input type="checkbox"/> Former spouse and any former stepchildren	<div><input type="checkbox"/> The employee must drop former spouse and stepchildren from health, dental and vision.</div> <div><input type="checkbox"/> Must drop Dependent Life for former spouse or stepchild, even if court ordered to continue.</div> <div><input type="checkbox"/> If divorce decree requires the employee to continue coverage for former spouse, former spouse can enroll in own coverage using this form.</div>	Health, dental and vision: First of month following divorce Dependent Life: Date of divorce Exception to 31-day rule: If dropping ineligible spouse or stepchildren and PEBA is notified more than 31 days after divorce, first of month following notification.	Entire divorce decree
	<input type="checkbox"/> Employee	<div><input type="checkbox"/> Enroll in or increase Optional Life up to \$50,000 without evidence of insurability</div> <div><input type="checkbox"/> Cancel or decrease Optional Life</div> <div><input type="checkbox"/> Review changes available with MSA</div>	Optional Life: If employee is actively at work, first of month following date of request. If not actively at work, first of month following return to work.	
Notes				
A. May not drop coverage for himself or any dependents who remain eligible for coverage. B. For Optional Life, if employee is not actively at work on the expected effective date, then the effective date will be first of the month following return to work.				

Special eligibility situations quick reference (cont.)

Event	This person/these people <i>(select one)</i>	Can do one or more of these actions <i>(select as many as apply)</i>	Effective date	Documentation required
Employee loses other health coverage (includes Medicare)	If employee is not already enrolled in PEBA's health coverage: <input type="checkbox"/> Employee <input type="checkbox"/> Employee and spouse <input type="checkbox"/> Employee and children <input type="checkbox"/> Employee, spouse and children	<input type="checkbox"/> Enroll in health <input type="checkbox"/> Enroll in Dental Plus or Basic Dental <input type="checkbox"/> Enroll in State Vision	Health, dental and vision: Date of loss of health coverage <i>If enrolled in MoneyPlus Pretax Premium feature, premiums must be paid post-tax for retroactive coverage back to the date of loss. Premiums may be paid through the Pretax Premium feature beginning first of the month following date of request.</i>	Letter (on company letterhead) stating employee lost health coverage and date of loss and Long-form birth certificate if adding child; marriage license or Page 1 of most recent tax return if adding spouse.
	If employee is already enrolled in PEBA health coverage: Not eligible to change elections.	Not eligible to change elections.		
Notes				
A. Letter does NOT have to state employee lost dental or vision to add dental or vision.				
B. Letter does not have to state spouse or children lost coverage to add them.				
C. May not drop any coverage but may add coverage.				

Special eligibility situations quick reference (cont.)

Event	This person/these people (<i>select one</i>)	Can do one or more of these actions (<i>select as many as apply</i>)	Effective date	Documentation required
Spouse or child loses other health coverage (includes Medicare)	<input type="checkbox"/> Employee and spouse/child who lost health coverage	<input type="checkbox"/> Enroll in health (if employee already enrolled in health, may change plans if adding spouse or child to health) <input type="checkbox"/> Enroll in Dental Plus or Basic Dental <input type="checkbox"/> Enroll in State Vision	Health, dental and vision: Date of loss of health coverage <i>If enrolled in MoneyPlus Pretax Premium feature, premiums must be paid post-tax for retroactive coverage back to the date of loss. Premiums may be paid through the Pretax Premium feature beginning first of the month following date of request.</i>	Letter (on company letterhead) stating spouse/child lost health coverage and date of loss and Long-form birth certificate if adding child; marriage license or Page 1 of most recent tax return if adding spouse.
Notes A. Letter does NOT have to say spouse/child lost dental or vision to add dental or vision. B. Employee may not make changes to coverage unless he adds spouse/child who lost health coverage. C. May not drop any coverage but may add coverage. D. If the spouse/child lost coverage through PEBA and he is then added to the employee's Dependent Life coverage, the effective date is the date of the loss or the first of the month following date of request, whichever is later.				

Special eligibility situations quick reference (cont.)

Event	This person/these people (<i>select one</i>)	Can do one or more of these actions (<i>select as many as apply</i>)	Effective date	Documentation required
Employee loses other dental coverage only (not health)	<input type="checkbox"/> Employee	<input type="checkbox"/> Enroll in Dental Plus or Basic Dental	Dental: Date of loss of dental coverage <i>If enrolled in MoneyPlus Pretax Premium feature, premiums must be paid post-tax for retroactive coverage back to the date of loss. Premiums may be paid through the Pretax Premium feature beginning first of the month following date of request.</i>	Letter (on company letterhead) stating employee lost dental coverage and date of loss.
Employee loses other vision coverage only (not health)	<input type="checkbox"/> Employee	<input type="checkbox"/> Enroll in State Vision	Vision: Date of loss of vision coverage <i>If enrolled in MoneyPlus Pretax Premium feature, premiums must be paid post-tax for retroactive coverage back to the date of loss. Premiums may be paid through the Pretax Premium feature beginning first of the month following date of request.</i>	Letter (on company letterhead) stating employee lost vision coverage and date of loss.
Spouse or child loses other dental coverage only (not health)	<input type="checkbox"/> Employee and spouse/child who lost health coverage	<input type="checkbox"/> Enroll in Dental Plus or Basic Dental	Dental: Date of loss of dental coverage <i>If enrolled in MoneyPlus Pretax Premium feature, premiums must be paid post-tax for retroactive coverage back to the date of loss. Premiums may be paid through the Pretax Premium feature beginning first of the month following date of request.</i>	Letter (on company letterhead) stating spouse/child lost dental coverage and date of loss.
Notes				
If spouse/child not covered by employee for health, vision or life, must also submit dependent documentation.				

Special eligibility situations quick reference (cont.)

Event	This person/these people (<i>select one</i>)	Can do one or more of these actions (<i>select as many as apply</i>)	Effective date	Documentation required
Spouse or child loses other vision coverage only (not health)	<input type="checkbox"/> Employee and spouse/child who lost health coverage	<input type="checkbox"/> Enroll in State Vision	Vision: Date of loss of vision coverage <i>If enrolled in MoneyPlus Pretax Premium feature, premiums must be paid post-tax for retroactive coverage back to the date of loss. Premiums may be paid through the Pretax Premium feature beginning first of the month following date of request.</i>	Letter (on company letterhead) stating spouse/child lost vision coverage and date of loss.
Notes				
If spouse/child not covered by employee for health, dental or life, must also submit dependent documentation.				
Employee gains other health, dental or vision coverage	<input type="checkbox"/> Employee	<input type="checkbox"/> Drop coverage gained	Health, dental, vision: First of the month following gain of coverage or the first of the month if coverage is gained on the first of the month.	Letter (on company letterhead) stating subscriber gained coverage and date of gain.
Notes				
A. Dependents enrolled in the same coverage must also be dropped.				
B. Cannot just drop Basic Dental or Dental Plus — must drop both if enrolled in both.				
Spouse/child gains other health, dental or vision coverage	<input type="checkbox"/> Spouse/child who gained other coverage	<input type="checkbox"/> Drop coverage gained	Health, dental, vision: First of the month following gain of coverage or the first of the month if coverage is gained on the first of the month.	Letter (on company letterhead) stating spouse/child gained coverage and date of gain.
Notes				
A. Cannot just drop Basic Dental or Dental Plus — must drop both if enrolled in both.				
B. Only the spouse/child listed on gain of coverage letter may drop.				

Special eligibility situations quick reference (cont.)

Event	This person/these people (<i>select one</i>)	Can do one or more of these actions (<i>select as many as apply</i>)	Effective date	Documentation required
Employee gains Medicaid or CHIP coverage	<input type="checkbox"/> Employee	<input type="checkbox"/> Drop health <input type="checkbox"/> Drop dental <input type="checkbox"/> Drop vision	Health, dental, vision: Exception to 31-day Rule: Employee has 60 days from the date notified by Medicaid of gain of coverage to drop health, dental and/or vision. If notified by Medicaid within 60 days of gain of coverage, date of gain of Medicaid. If notified by Medicaid more than 60 days after gain of coverage, first of month following request. (See Note B below)	Copy of Medicaid approval letter.
Notes A. Spouse or children enrolled in the same coverage will also be dropped. B. If the employee contacts PEBA later than 60 days after he was notified by Medicaid, no change can be made due to gain of Medicaid.				
Spouse/child gains Medicaid or CHIP coverage	<input type="checkbox"/> Spouse/child who gained Medicaid or CHIP coverage	<input type="checkbox"/> Drop health <input type="checkbox"/> Drop dental <input type="checkbox"/> Drop vision	Same as above	Copy of Medicaid approval letter.
Notes A. Only the spouse/child listed on gain of coverage letter may drop. B. If the employee contacts PEBA later than 60 days after dependent was notified by Medicaid, no change can be made due to gain of Medicaid.				

Special eligibility situations quick reference (cont.)

Event	This person/these people <i>(select one)</i>	Can do one or more of these actions <i>(select as many as apply)</i>	Effective date	Documentation required
Employee loses Medicaid or CHIP coverage	If employee is not already enrolled in PEBA's health coverage: <input type="checkbox"/> Employee <input type="checkbox"/> Employee and spouse <input type="checkbox"/> Employee and children <input type="checkbox"/> Employee, spouse and children	<input type="checkbox"/> Enroll in health <input type="checkbox"/> Enroll in Dental Plus or Basic Dental <input type="checkbox"/> Enroll in State Vision	Health, dental and vision: Exception to 31-day rule: <ul style="list-style-type: none">Employee has 60 days from the date notified by Medicaid of loss of coverage to enroll.If notified by Medicaid within 60 days, date of loss of Medicaid.If notified by Medicaid more than 60 days after loss, first of month following request. (See Note C below)<i>If enrolled in MoneyPlus Pretax Premium feature, premiums must be paid post-tax for retroactive coverage back to the date of loss. Premiums may be paid through the Pretax Premium feature beginning first of the month following date of request.</i>	Copy of Medicaid loss letter and Long-form birth certificate if adding child; marriage license or Page 1 of most recent tax return if adding spouse.
	If employee is already enrolled in PEBA health coverage: Not eligible to change elections	Not eligible to change elections		
	Notes A. Letter does not have to state spouse or children lost coverage to add them. B. May not drop any coverage but may add coverage. C. If the employee contacts PEBA later than 60 days after he was notified by Medicaid, no change can be made due to gain of Medicaid.			
Spouse/child loses Medicaid or CHIP coverage	<input type="checkbox"/> Employee and spouse/child who lost health coverage	<input type="checkbox"/> Enroll in health (if employee already enrolled in health, may change plans if adding spouse or child to health) <input type="checkbox"/> Enroll in Dental Plus or Basic Dental <input type="checkbox"/> Enroll in State Vision	Same as above	Copy of Medicaid loss letter and Long-form birth certificate if adding child; marriage license or Page 1 of most recent tax return if adding spouse.
Notes A. May only add the employee with the spouse/child who lost Medicaid. B. May not drop any coverage but may add coverage.				

Special eligibility situations quick reference (cont.)

Event	This person/these people <i>(select one)</i>	Can do one or more of these actions <i>(select as many as apply)</i>	Effective date	Documentation required
Employee gains premium assistance through Medicaid or CHIP	If employee is not already enrolled in PEBA's health coverage: <input type="checkbox"/> Employee	<input type="checkbox"/> Enroll in health <input type="checkbox"/> Enroll in Dental Plus or Basic Dental <input type="checkbox"/> Enroll in State Vision	Health, dental and vision: Exception to 31-day rule: <ul style="list-style-type: none">Employee has 60 days from the date notified of gain of Medicaid premium assistance to enroll.If notified by Medicaid within 60 days, date of gain of assistance.If notified by Medicaid more than 60 days after gain, first of month following request.<i>If enrolled in MoneyPlus Pretax Premium feature, premiums must be paid post-tax for retroactive coverage back to the date of loss. Premiums may be paid through the Pretax Premium feature beginning first of the month following date of request.</i>	Copy of Medicaid approval letter
	If employee is already enrolled in PEBA health coverage: Not eligible to change elections	Not eligible to change elections		
	Notes A. May not drop any coverage but may add coverage. B. If the employee contacts PEBA later than 60 days after he was notified by Medicaid, no change can be made due to gain of Medicaid premium assistance.			
Spouse/child gains premium assistance through Medicaid or CHIP	<input type="checkbox"/> Employee and spouse/child who gained Medicaid or CHIP premium assistance	<input type="checkbox"/> Enroll in health (if employee already enrolled in health, may change plans if adding spouse or child to health) <input type="checkbox"/> Enroll in Dental Plus or Basic Dental <input type="checkbox"/> Enroll in State Vision	Same as above	Copy of Medicaid approval letter and Long-form birth certificate if adding child; marriage license or Page 1 of most recent tax return if adding spouse
Notes A. May only add the employee with the spouse/child who Medicaid gain letter. B. May not drop any coverage but may add coverage.				

Special eligibility situations quick reference (cont.)

Event	This person/these people <i>(select one)</i>	Can do one or more of these actions <i>(select as many as apply)</i>	Effective date	Documentation required
Employee loses premium assistance through Medicaid or CHIP	<input type="checkbox"/> Employee	<input type="checkbox"/> Drop health <input type="checkbox"/> Drop Dental <input type="checkbox"/> Drop Vision	Health, dental and vision: Exception to 31-day rule: <ul style="list-style-type: none">Employee has 60 days from the date notified of loss of Medicaid premium assistance to enroll.If notified by Medicaid within 60 days, date of loss.If notified by Medicaid more than 60 days after gain, first of month following request.	Copy of Medicaid loss letter
Notes A. If the employee drops coverage, spouse or children enrolled in the same coverage will also be dropped. B. If the employee contacts PEBA later than 60 days after he was notified by Medicaid, no change can be made due to loss of Medicaid premium assistance.				
Spouse/child loses premium assistance through Medicaid or CHIP	<input type="checkbox"/> Spouse/child who lost Medicaid or CHIP premium assistance	<input type="checkbox"/> Drop health <input type="checkbox"/> Drop Dental <input type="checkbox"/> Drop Vision	Same as above	Copy of Medicaid loss letter
Notes A. Only the spouse/child listed on loss of premium assistance letter may drop. B. If the employee contacts PEBA later than 60 days after he was notified by Medicaid, no change can be made due to loss of Medicaid premium assistance.				
Employees not enrolled in the MoneyPlus Pretax Group Insurance Premium feature can also make the following changes:				
Marital separation	<input type="checkbox"/> Employee's separated spouse	<input type="checkbox"/> Drop health, dental and vision	First of the month following date of notification	Decree of Separate Maintenance or other order filed with court
	<input type="checkbox"/> Employee	<input type="checkbox"/> Enroll in or increase Optional Life up to \$50,000 <input type="checkbox"/> Cancel or decrease Optional Life	Optional Life: if employee is actively at work, first of month following date of request. If not actively at work, first of month after return to work.	
Notes A. Must notify within 31 days of court order or no election change can be made. B. If dropping a separated spouse, this is an all-or-nothing election change for all the benefits listed in Column 3. The employee may not choose among the options. C. For Optional Life, if employee is not actively at work on the expected effective date, then the effective date will be first of the month following return to work.				

Effective date quick reference

Type of action	Effective date
New hire	<ul style="list-style-type: none"> If the employee begins active employment on the <i>first day</i> of the month, coverage begins on that day (on the 1st of the month). If the employee begins active employment on the <i>first working day</i> of the month (first day that is not a Saturday, Sunday or observed holiday), but not on the <i>first day</i> of the month (for example, he begins on the 2nd or 3rd of the month), then the employee may choose when coverage begins: <ul style="list-style-type: none"> The first day of that month, OR The first day of the following month. If the employee begins active employment <i>after</i> the first working day of the month (after the first day that is not a Saturday, Sunday or observed holiday), coverage will begin the first day of the following month.
Birth	See the Special Eligibility Situations Quick Reference chart for effective dates.
Adoption	
Foster care/guardianship	
Marriage	
Separation	
Divorce	See the Special Eligibility Situations Quick Reference chart for effective date.
Employee loss of coverage	See the Special Eligibility Situations Quick Reference chart for effective date.
Spouse/child loss of coverage	
Employee gain of coverage	
Spouse/child gain of coverage	
Employee gain of Medicaid or CHIP coverage or loss of premium assistance	See the Special Eligibility Situations Quick Reference charts for effective date.
Spouse/child gain of Medicaid or CHIP coverage or loss of premium assistance	See the Special Eligibility Situations Quick Reference charts for effective date.
Employee loss of Medicaid or CHIP coverage or gain of premium assistance	See the Special Eligibility Situations Quick Reference charts for effective date.
Spouse/child loss of Medicaid or CHIP coverage or gain of premium assistance	See the Special Eligibility Situations Quick Reference charts for effective date.
Spouse/child of Foreign National Employee	Date of arrival in the U.S. to add; first of the month following departure from the U.S. to drop.
Late entrant (health) (<i>no medical evidence of good health</i>)	January 1 following open enrollment.
Ineligible spouse or child	First of the month after becoming ineligible.
Returning student	First of the month after becoming eligible.
Death (health, dental, SLTD)	One day after date of death.
Death (Optional Life)	Date of death.
Social Security Number	N/A
Name	N/A
Address	N/A

Effective date quick reference (cont.)

Type of action	Effective date
Beneficiary changes (all plans)	Date of the signature on the NOE.
Optional Life increase throughout the year (not on MoneyPlus)	First of the month after approval of medical evidence. Deferred effective date provision applies.
Optional Life decrease or cancellation (not on MoneyPlus)	First of the month after request.
Optional Life increase due to special eligibility situation	See the Special Eligibility Situations Quick Reference charts.
Optional Life decrease or cancellation for MoneyPlus participants	See the Special Eligibility Situations Quick Reference charts.
Optional Life increase due to annual enrollment	Following January 1 for amount available without medical evidence, or first of month after approval of medical evidence if it is required for amount requested, whichever is later. Deferred effective date provision applies.
Optional Life decrease or cancellation due to annual enrollment	Following January 1.
Dependent Life-Spouse enrollment or increase throughout the year (when medical approval is required)	First of the month after approval. Deferred effective date provision applies.
Dependent Life-Spouse enrollment or increase due to special eligibility situation	See the Special Eligibility Situations Quick Reference charts.
Dependent Life-Child enrollment throughout the year	Date of birth for newborns. First of the month after date of request for other children. Deferred effective date provision applies to children other than newborns.
Retirement (service)	First of the month after retirement eligibility has been established.
Retirement (disability)	First of the month following the date on the approval letter from PEBA Retirement Benefits (disability retirement) or The Standard (BLTD/SLTD).

Documentation quick reference

Type of action	Documentation required
Administrative error	Statement explaining error and circumstances on a Request for Review Form , with any supporting documentation attached.
Adoption/placement for adoption	Copy of a birth certificate listing the subscriber as the parent; or a copy of legal adoption documentation from the court, verifying the completed adoption; or a letter of placement from an attorney, adoption agency or DSS, verifying the adoption in progress.
Divorce Decree or Court Order to Insure Ex-spouse or Child(ren)	Copy of the entire divorce decree or court order. Document must stipulate the programs under which the spouse or child must be covered.
Custody or Guardianship of Child(ren)	Copy of court order or other legal documentation from a placement agency or DSS, granting custody or guardianship of a child/foster child to the subscriber. The documentation must verify the subscriber has guardianship responsibility for the child and not merely financial responsibility.
Death in the line of duty	Verification of death while on duty.
Dependent Life (adding or increasing when medical evidence is required)	Copy of approval from MetLife.
Divorce Decree (drop spouse)	Copy of the entire divorce decree (<i>See also Divorce Decree or Court Order to Insure Former Spouse or Child(ren) above</i>).
Divorce or annulment of married child (to add child) (For Dependent Life only)	Copy of divorce decree or documentation of annulment, along with proof of eligibility as a full-time student or incapacitated child, if child is age 19 or older.
Enrolling a child	Copy of the long-form birth certificate showing the subscriber as the parent.
Enrolling a spouse	Copy of marriage license or Page 1 of federal tax return.
Enrolling a stepchild	Copy of the long-form birth certificate showing name of natural parent plus proof natural parent and subscriber are married.
Foreign national	Copy of entry stamp/departure stamp from visa.
Gain Medicare coverage	Copy of Medicare card.
Gain/Loss Medicaid coverage	Letter from the Department of Health and Human Services, confirming Medicaid approval and effective date or confirming Medicaid coverage is ending and the effective date.
Gain/Loss other coverage	Copy of creditable coverage letter or copy of letter on company letterhead that includes: Date coverage gained/lost, individuals who gained/lost coverage, type(s) of coverage gained/lost and reason for gain/loss.
Incapacitation	Incapacitated Child Certification Form , completed by both the subscriber and the child's physician. For Dependent Life only, if child is ages 19-24, must also include letter from educational institution, confirming withdrawal from school as a full-time student.
Medicare correction	Copy of Medicare card.
Medicare due to disability	Copy of Medicare card.
Military activation	Copy of military orders.
Military — return from duty	Copy of military discharge papers.
Name change	Copy of driver's license, Social Security card, order of name change or vital records certificate.

Documentation quick reference (cont.)

Type of action	Documentation required
Optional Life (adding or increasing when medical evidence is required)	Copy of approval from MetLife.
Retirement — Disability	Copy of approval letter from the S.C. Retirement Systems or Standard Insurance Company.
Retirement — Service	Copy of signed Employment Verification Record form.
Separation (to drop spouse)	Copy of a court order, signed by a judge. The court order must state that the divorce is in progress. <i>Cannot be done outside open enrollment or finalized divorce by subscribers with MoneyPlus.</i>
SSN Correction	Copy of Social Security card.
Student Certification	Statement on letterhead, from the educational institution, stating student is full time and dates of enrollment.
Supplemental Long Term Disability (adding/increasing when medical evidence is required)	Copy of the approval from The Standard.

Active Termination Form quick reference

Submit terminations through EBS when permissible.

Action	Employee Information	Coverage/Dates	Certification
NOT ELIGIBLE: enter last day worked and check applicable reason	#1-7	Effective date and all plans in which enrolled.	COBRA and/or Conversion for OL (if applicable). Sign and date.
TRANSFER TO: new group ID # and group name	#1-7	Effective date and all plans in which enrolled.	COBRA and/or Conversion for OL (if applicable). Sign and date.
MILITARY LEAVE	#1-7	Effective date and all plans in which enrolled.	COBRA and/or Conversion for OL (if applicable). Sign and date.
NONPAYMENT	#1-7	Effective date and all plans in which enrolled.	Conversion for OL (if applicable). Sign and date.
SERVICE RETIREMENT: must meet criteria for PEBA Retirement Benefits and retiree insurance	#1-7	Effective date and all plans in which enrolled.	COBRA, Retiree and Conversion or Continuation for OL (if applicable). Sign and date.
DISABILITY: approved for BLTD/SLTD and/or PEBA Retirement Benefits disability	#1-7	Effective date and all plans affected by termination (OL can be continued). Do not terminate OL if in waiver; complete OL waiver form.	COBRA, Retiree and Conversion or Continuation for OL (if applicable). Sign and date.
DECEASED: enter date of death	#1-7	Effective date and all plans in which enrolled.	Sign and date only.

Affordable Care Act glossary

New full-time employee (Permanent or Nonpermanent)	A newly hired employee who was determined by the employer, as of the date of hire, to be full-time and eligible for benefits.
New variable-hour, part-time or seasonal employee	A newly hired employee who is not expected to be credited an average of 30 hours per week for the entire measurement period, as of the date of hire. Therefore, the employer cannot reasonably determine his eligibility for benefits as of the date of hire.
Ongoing employee	Any employee who has worked with an employer for an entire Standard Measurement Period.
Plan year	January 1 to December 31.
Applies to new variable-hour, part-time and seasonal employees	
Initial Measurement Period	Begins the first of the month after the date of hire and ends 12 months later. The employer should review the employee's hours over the Initial Measurement Period to determine future eligibility for benefits.
Initial Administrative Period	Begins the day after the initial measurement period ends and ends the last day of the same month. The employer uses this time to review the employee's hours over the initial measurement period, and, if the employee is eligible, offers benefits to the employee the first of the following month.
Initial Stability Period	Begins the day after the Initial Administrative Period ends and lasts for 12 months. This is the period of time that an employee cannot lose eligibility for benefits regardless of the number of hours he works. If the employee is deemed eligible for coverage during the Initial Administrative Period, he remains eligible for 12 months as long as he remains employed by the employer.
Applies to all ongoing employees	
Standard Measurement Period	Begins on October 4 and ends 12 months later, on October 3. The employer will review the employee's hours over the Standard Measurement Period to determine eligibility for the upcoming plan year.
Administrative Period	Begins on October 3 and ends December 31. This is the period of time an employer and the plan have to identify and enroll eligible individuals in coverage. Employers must offer coverage to eligible employees during the plan's open enrollment period, which ends October 31. PEBA uses the remainder of the Administrative Period to process enrollments to ensure employees have access to coverage at the beginning of the Stability Period.
Stability Period	Begins on January 1 and ends 12 months later on December 31. This is the period of time that an ongoing employee cannot lose eligibility for benefits regardless of the number of hours he works. If the employee is deemed eligible for coverage during the Administrative Period, he remains eligible for the entire plan year as long as he remains employed with the employer.

For more information on the Affordable Care Act, including frequently asked questions, go to <http://www.peba.sc.gov/aca.html>.

Quick reference calendar for determining eligibility

This chart helps determine eligibility for new variable-hour, part-time and seasonal employees. After an employee has been employed for a full Standard Measurement Period, he becomes an ongoing employee, and his hours should be reviewed during the open enrollment period (with all other ongoing employees) to determine his eligibility for benefits in the next plan year.

Month employee began work	Initial Measurement Period (12 months)	Administrative Period	Initial Stability Period (12 months)
	<i>Begins the 1st of the month after the date of hire. During this period, an employer would measure the employee's hours.</i>	<i>Immediately follows the Initial Measurement Period. Employer should review the hours worked during the Initial Measurement Period. If the employee averages 30 hours or more per week, he is eligible for benefits.</i>	<i>Immediately follows the Administrative Period. If the employee is deemed eligible for benefits during the Administrative Period, this is the period of time the employee remains eligible for benefits regardless of the number of hours worked.</i>
January	Feb. 1-Jan. 31	Feb. 1-28	March 1-Feb. 28
February	March 1-Feb. 28	March 1-31	April 1-March 31
March	April 1-March 31	April 1-30	May 1-April 30
April	May 1-April 30	May 1-31	June 1-May 31
May	June 1-May 31	June 1-30	July 1-June 30
June	July 1-June 30	July 1-31	Aug. 1-July 31
July	Aug. 1-July 31	Aug. 1-31	Sept. 1-Aug. 31
August	Sept. 1-Aug. 31	Sept. 1-30	Oct. 1-Sept. 30
September	Oct. 1-Sept. 30	Oct. 1-31	Nov. 1-Oct. 31
October	Nov. 1-Oct. 31	Nov. 1-30	Dec. 1-Nov. 30
November	Dec. 1-Nov. 30	Dec. 1-31	Jan. 1-Dec. 31
December	Jan. 1-Dec. 31	Jan. 1-31	Feb. 1-Jan. 31

Quick reference for unpaid leave or reduction in hours

This information describes how eligibility for insurance benefits is affected when an employee goes on an employer-approved leave of absence that is not associated with military leave or FMLA.

Employee's status	When unpaid leave (or reduction of hours) begins	Premium information	Employee's options	When employee returns from unpaid leave (or hours are increased)
Ongoing Employee (in a stability period) or variable-hour, part-time and seasonal employee (in an Initial Stability Period)	<p>Eligibility for health, dental and vision continues through the end of the stability period.</p> <p>Employer should send the employee the Your Insurance Benefits When Your Hours are Reduced form.</p>	<p>Employee pays employee's share; employer pays employer's share. If employee fails to pay within the grace period, employer can submit termination to PEBA to terminate coverage. Employee is not eligible for COBRA.</p>	<p>Employee may choose to voluntarily drop coverage to enroll in the Marketplace. If employee elects to drop coverage for this reason, employer should submit termination to PEBA.</p>	<p>If employee continued coverage while on unpaid leave, no action required.* If employee voluntarily dropped coverage to enroll in Marketplace (or if coverage was terminated due to nonpayment), employee can enroll within 31 days of special eligibility situation or during open enrollment (if eligible). *If SLTD or life insurance were terminated, employee may enroll with medical evidence.</p>
New variable-hour, part-time or seasonal employee (Not in a stability period)	Employee's eligibility has not yet been established.	N/A	N/A	<p>If employee returns to work with same employer as a variable-hour, part-time or seasonal employee: Less than a 13-week break (26-weeks if academic employer), the initial measurement period continues. 13-week break or more (26-week break or more if academic employer), the initial measurement period begins the first of the month following return to work.</p>
New full-time employee (Employee is not in a stability period nor on FMLA nor on military leave)	<p>Eligibility for active benefits ends first of the month following employee's last day of paid work or first of the month following his reduction of hours. Employer sends employee the Your Insurance Benefits When Your Hours are Reduced form. Employer submits termination to PEBA and sends the 18-month COBRA notice to employee.</p>	Refer to COBRA rates	Employee and covered dependents may continue coverage through COBRA for up to 18 months (COBRA qualifying event is a reduction of hours).	Eligibility for active benefits begins the first of the month following the employee's return to work or resumption of working 30 hours per week.

Employer checklists

Comprehensive PEBA employer checklists for life events are available at www.peba.sc.gov/employers.html.

- [New employee.](#)
- [Marriage.](#)
- [Birth.](#)
- [Adoption.](#)
- [Divorce.](#)
- [Leaving employment.](#)
- [Service retirement.](#)
- [Disability retirement.](#)
- [Death – employee.](#)
- [Death – dependent.](#)

Coverage termination checklists

Termination of employment due to resignation, RIF, dismissal

Effective date is the first of the month after the last day worked.

- ☐ Submit termination to PEBA immediately. Do not delay!
 - EBS termination: Left employment.
 - [Active Termination Form](#): Not eligible (T5) Complete an Active Termination Form.
- ☐ Offer the employee and his spouse and/or children COBRA enrollment information by letter.
- ☐ Refer to the *COBRA subscribers* section of this manual for additional information.

ASIFlex will send the Medical Spending Account COBRA qualifying event letter to the employee if he qualifies for COBRA continuation. The employee may continue a Medical Spending Account for the rest of the year on an **after-tax basis** through COBRA by electing coverage and paying monthly amounts in a timely manner.

If the terminating employee's spouse is a covered employee or retiree, the terminating employee may be added to the spouse's coverage and other eligible programs within 31 days. If enrolled within 31 days:

- The employee may convert Basic Life, Optional Life, Dependent Life-Spouse and/or Dependent Life-Child coverage.
- The employee may convert SLTD coverage if he meets the criteria.
- If eligible, the employee may continue to contribute to a Health Savings Account directly through Central Bank.

Termination of employment with transfer to another PEBA-participating employer

- ☐ Submit termination to PEBA immediately. Do not delay!
 - EBS termination: Transfer.
 - [Active Termination Form](#): Transfer (TT).

Include the group name and number to which the employee is transferring.

- ☐ Offer the employee and his spouse and/or children COBRA enrollment information by letter.
- ☐ Refer to the *COBRA subscribers* section of this manual for additional information.

Refer to the *Transfers and Terminations* section of this manual for additional information.

Termination of employment due to retirement (service or disability)

Effective date is the first of the month after retirement eligibility has been established. If it is a disability retirement, the effective date will be the first of the month following the date on the approval letter from PEBA Retirement Benefits or The Standard (BLTD/SLTD) in certain situations.

For more information on retirement eligibility refer to the [Insurance Benefits Guide](#).

- ☐ Submit termination to PEBA immediately. Do not delay!
 - EBS termination: Retired or Disability retired.
 - [Active Termination Form](#): Service retirement (T7) or Disability retirement (T2).
- ☐ Provide the [Retiree Packet](#) to the employee. The required forms for establishing eligibility, enrolling in retiree insurance and certifying tobacco use are included in the packet.
 - Document in the employee's file the date you provided or mailed the *Packet*.
- ☐ Offer the employee and his spouse and/or children COBRA enrollment information by letter.
- ☐ Refer to the *COBRA subscribers* section of this manual for additional information.

ASIFlex will send the Medical Spending Account (MSA) COBRA qualifying event letter to the employee if he qualifies for COBRA continuation. The employee may continue the MSA for the rest of the year on an **after-tax basis** through COBRA by electing coverage and paying the monthly amounts in a timely manner.

The employee may continue the MSA for the rest of the year on a **pretax basis** if:

- The employee declined COBRA continuation coverage;
- The employee elected in advance, on his last enrollment form, to accelerate his pretax deductions up to the full, annual amount; or
- The remainder of his full, annual election was deducted from his final paycheck(s).

Refer to the *Retiree subscribers* section of this manual for additional information.

Termination due to death of subscriber

Effective date is the day after date of death, except for Optional Life (date of death).

- ☐ Submit termination to PEBA immediately. Do not delay!
 - EBS termination: Death.
 - [Active Termination Form](#): Deceased (T1).

Forward a copy of the death certificate/documentation to PEBA immediately.

- ☐ Complete the [Life insurance claim form](#) and send along with coverage verification and beneficiary information to MetLife. If the death was accidental, attach the police/accident report, newspaper article, etc., and write Accidental at the top of the form.
- ☐ If the employee was receiving disability benefits, send a copy of the *claim form* to The Standard so that any potential benefits may be paid to eligible survivors.
- ☐ Explain survivor benefits to any covered spouse and/or children.

Refer to the *Survivors* section of this manual for additional information.

Termination due to non-payment of premiums

Effective the first of the month following the last month in which premiums were due and paid in full.

- ☐ Submit termination to PEBA immediately. Do not delay!
 - [Active Termination Form](#): Nonpayment (TN).

Optional employers should complete the appropriate termination for Retiree, COBRA and Survivor subscribers.

Do not send COBRA notification letters because COBRA does not apply.

If the employee returns to work after coverage is terminated, he is only permitted to re-enroll during open enrollment or within 31 days of gaining eligibility under a provision of the Plan, such as a special eligibility situation. Returning to work is **not** a special eligibility situation that allows an employee to re-enroll in benefits.

Termination during military leave

- ☐ Submit termination to PEBA immediately. Do not delay!
 - [Active Termination Form](#): Military leave (TM).
- ☐ If not continuing coverage during leave, refer to the information in Military Leave in the Active subscribers' chapter.

A copy of the employee's military orders is required.

If the employee does not continue coverage during military leave, refer to the *Military Leave* information in the *Active subscribers* section of this manual. Coverage may be reinstated within 31 days of returning to work.

Termination of covered spouse and/or child

Coverage changes must be made within 31 days of a special eligibility situation. *Exception: State Vision Plan.*

Coverage changes may be made during the next October enrollment period.

- ☐ Submit in EBS or complete a paper [Active Notice of Election](#) to terminate coverage and change coverage level, if applicable.
 - Upload or attach any supporting documentation, if applicable. If submitting on paper and, if the subscriber's tobacco-use status has changed, attach a completed [Certification Regarding Tobacco or E-cigarette Use](#) form.
- ☐ Offer the employee and his spouse and/or children COBRA enrollment information by letter. Refer to the *COBRA subscribers* section of this manual for additional information.
- ☐ If the spouse or child is covered under Dependent Life insurance, that coverage can be converted.

Death of covered spouse or child

- ☐ Complete an Active NOE to terminate coverage of a deceased spouse or child and change coverage level, if applicable.
 - *Effective date*: day after death.
 - Forward a copy of the form to PEBA.
- ☐ Complete the *Life Insurance Claim* form and send it, along with coverage verification and beneficiary information, to MetLife for Dependent Life benefits.
- ☐ If applicable, complete *Notice of Election* form and send to PEBA if the employee is making a change to his Medical Spending or Dependent Care Spending account.

Retiree orientation checklist

Determining retiree insurance eligibility is complicated, and only PEBA can make that determination. Provide the [Retiree Packet](#) to the employee.

Explain that enrollment in retiree insurance coverage is not automatic. To enroll in retiree insurance, he will first need to confirm his eligibility for retiree group insurance by completing and submitting an [Employment Verification Record](#) to PEBA. This may be done up to six months prior to his anticipated retirement date. It is very important to contact PEBA before making final arrangements for retirement.

If PEBA determines that he is eligible for retiree insurance coverage, he must complete and submit the [Retiree Notice of Election](#) and any other applicable forms within 31 days of his retirement date. These completed forms should be submitted to PEBA for state agency, public school district or higher education institution employees. These forms may be submitted to the employer's benefits office for optional employers.

At retirement, MetLife will mail a conversion/continuation packet. The packet will include instructions for available options. Call MetLife at 888.507.3767 if the retiree does not receive the packet.

Refer to the *Retiree group insurance* chapter of the Insurance Benefits Guide for a detailed description of benefits for retirees. Medicare-eligible retirees should refer to the [Insurance Coverage for the Medicare-eligible Member](#) guide.

Explain optional employer funding, if applicable.

Health insurance

- ☐ Review options and benefits.
 - If the employee and his eligible spouse and/or children are not eligible for Medicare, he cannot choose the Medicare Supplemental Plan.
 - If eligible for, or enrolled in, Medicare:
 - Enroll in Part A **and** Part B for maximum coverage and to avoid the carve-out method of claims payment. The employee must notify his employer and PEBA as soon as he becomes eligible.
 - Subscribers covered by the Medicare Supplemental Plan or the Standard Plan will be automatically enrolled in the State Health Plan Medicare Prescription Drug Program, a group-based Medicare Part D Prescription Drug Plan (PDP). In most cases, a retiree will be better served if he remains enrolled in the Medicare Part D plan sponsored by PEBA. If the retiree enrolls in a separate Part D plan, he loses prescription drug coverage with his plan through PEBA.
 - If eligible for Medicare, the retiree is no longer eligible for the Savings Plan or an HSA.
- ☐ If the tobacco-use status for the retiree is changing, attach a [Certification Regarding Tobacco or E-cigarette Use](#) form to the [Retiree NOE](#).
- ☐ Must wait until next open enrollment period or special eligibility situation if **not** enrolled within 31 days of retirement date.

Dental Plus and Basic Dental

- ☐ Review options and benefits.
- ☐ Must wait until next open enrollment period of an odd-numbered year or special eligibility situation if **not** enrolled within 31 days of retirement date.

State Vision Plan

- ☐ Review State Vision Plan benefits.
- ☐ Must wait until next open enrollment period or within 31 days of loss of other vision coverage if **not** enrolled within 31 days of retirement date.

Life insurance

- ☐ If the employee is eligible for retirement benefits through PEBA, he may choose to continue OR convert his Optional Life coverage with MetLife.
 - MetLife will mail a conversion/continuation packet via U.S. mail three to five business days after MetLife receives the eligibility file from PEBA.
 - To continue coverage, the retiree must complete the form that will be included in his packet from MetLife. Coverage must be elected within 31 days of the date of coverage is lost due to approved retirement or approved disability retirement.
 - To convert coverage, the retiree must follow the instructions in the packet from MetLife. Coverage must be converted within 31 days of the date of coverage is lost due to approved retirement or approved disability retirement. It is the retiree's responsibility to contact MetLife regarding conversion.

Long term disability

- ☐ Basic long-term disability coverage ends at retirement.
- ☐ Supplemental long-term disability coverage ends at retirement.

MoneyPlus

- ☐ MoneyPlus is **not** available in retirement (HSA exception below). Generally, an employee's period of coverage for the flexible spending accounts will end at retirement, with this exception:
 - A Medical Spending Account participant may accelerate his pretax deductions, to extend his period of coverage through the end of the plan year. Otherwise, he may continue coverage on an after-tax basis through COBRA as explained in the IBG.
- ☐ A retiree may continue to contribute to an HSA as long as enrolled in the Savings Plan (or other high deductible health plan) as sole coverage, until eligible for Medicare. Contributions in retirement are paid directly to Central Bank or other HSA custodian, not through payroll deduction or ASIFlex.

Additional information to explain

- ☐ The retiree will receive from PEBA:
 - A letter from PEBA, confirming retiree coverage.
 - A Certificate of Creditable Coverage, since active benefits are ending.
 - A COBRA notification letter, since active benefits are ending. (BA to send the Qualifying Event Notice according to procedures in COBRA subscribers' chapter.)
- ☐ Premiums for health, dental and vision may be paid directly from his PEBA Retirement Benefits annuity payment, if the annuity payment is enough to cover the premiums.
 - *Exception:* PEBA bills optional employers and those retirees who are not yet receiving annuity payments from PEBA Retirement Benefits.
 - Retirement benefits are paid at the end of the month, for that month (in arrears). However, insurance premiums are deducted at the end of the month, for the next month (in advance).
 - Based on the effective date of retirement, when the Retiree NOE is submitted and processing time, more than one month's premiums may be deducted from the first retirement check.

- ☐ If retiring due to disability, a copy of the disability approval letter from PEBA Retirement Benefits or Standard Insurance Company must be sent to PEBA as soon as it is received. The effective date for insurance purposes will be the first of the month following the date on the approval letter from PEBA Retirement Benefits or The Standard (if retiree is a State ORP participant or if employer is not a covered employer through PEBA Retirement Benefits).

Disability checklist

- ☐ The employee should complete and submit an Application for Disability Retirement to PEBA Retirement Benefits, if applicable. The BA may apply on behalf of the employee if he is unable to do so.
- ☐ The employee should complete and submit a [Long Term Disability Claim Form](#) packet to The Standard. The BA may apply on behalf of the employee if he is unable to do so.
- ☐ SLTD premium waiver begins the first of the month after the end of the benefit waiting period. Premiums should continue until then. The Standard will contact PEBA, the BA and the employee after approving the claim.
- ☐ The employee may continue MoneyPlus while on disability leave. If the employee does not wish to continue MoneyPlus, notify ASIFlex via the employer portal that the employee is on leave and will not be continuing his contributions.
- ☐ If the employee returns to work after a disability:
 - ☐ Complete and send the [SLTD Premium Waiver Form](#) to PEBA.
 - ☐ Contact The Standard.

For more information, see Disability Subscribers.

Claims checklist

- ☐ Make sure you are using the proper claim form for the program as instructed in Claims and Appeals.
- ☐ Be certain that each required section has been completed and the information is legible and correct.
- ☐ Make sure the claimant's name is listed exactly as it is on the NOE or in EBS.
- ☐ Ensure that the SSN or BIN of the employee/retiree is used for himself and for his covered spouse and/or children. The providers use individual Medicare numbers when filing for health benefits through Medicare, with Medicare as the primary payer.
- ☐ Attach proper and complete documentation as requested, based on the type of claim.
- ☐ Send the completed claim form to the address listed on the form.
- ☐ For MoneyPlus flexible spending account claims, keep a copy of the MoneyPlus Claim Form, including any itemized receipts or explanation of benefits statements. HSA participants are responsible for maintaining their own documentation.

Accounting system checklist

- ☐ All balances are due to PEBA on the 10th of the month and must be paid as billed. Do not adjust the billing statement.
- ☐ Payment is due as billed. The collection of premiums has no bearing on payment. Do not delay the regular remittance of monthly premiums due to failure to collect payments from subscribers.
- ☐ Employers must pay no less than the current employer share of the premiums for their active employees.
- ☐ All payments should be made payable to PEBA. If your office also pays for retiree, survivor and COBRA subscriber coverage, submit a separate check for these premiums. See also Submitting Premium Payments to PEBA on Page 152.
- ☐ You must return a completed remittance advice form with every payment. Do not return any other section of the billing statement with your payment.
- ☐ Use the return envelope provided, or mail your payment to PEBA's Financial Services Department using the following mailing address:
S.C. PEBA
Attn: Insurance Finance Department
P.O. Box 11661
Columbia, SC 29211
- ☐ If there is a keying error on the coverage processing section of the bill, please call the Customer Contact Center at 803.737.6800 or 888.260.9430.
- ☐ If you have a question about the Account Summary or Billing Summary, call PEBA's Financial Services Department at 803.734.1696 or 888.260.9430.
- ☐ Payment of one month's advance billing is due by July 15 of each year for active employees. The advance billing is the total employer contribution for health, dental, life and LTD as determined by PEBA enrollment files for July.



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